

Durham Research Online

Deposited in DRO:

08 February 2012

Version of attached file:

Published Version

Peer-review status of attached file:

Unknown

Citation for published item:

Brown, J. and Horvath, M. and Kelly, L. and Westmarland, N. (2010) 'Connections and disconnections : assessing evidence, knowledge and practice in responses to rape.', Project Report. Government Equalities Office, London.

Further information on publisher's website:

<http://homeoffice.gov.uk/equalities/equality-government/>

Publisher's copyright statement:

Additional information:

Use policy

The full-text may be used and/or reproduced, and given to third parties in any format or medium, without prior permission or charge, for personal research or study, educational, or not-for-profit purposes provided that:

- a full bibliographic reference is made to the original source
- a [link](#) is made to the metadata record in DRO
- the full-text is not changed in any way

The full-text must not be sold in any format or medium without the formal permission of the copyright holders.

Please consult the [full DRO policy](#) for further details.



Government
Equalities Office

Putting equality at the heart of government

**Connections and
disconnections:
Assessing evidence,
knowledge and
practice in
responses
to rape**

April 2010

This research was commissioned by the Government Equalities Office (GEO). The findings and recommendations are those of the authors and do not represent the views of the GEO or government policy. While the GEO has made every effort to ensure the information in this document is accurate, the GEO does not guarantee the accuracy, completeness or usefulness of that information.



Connections and disconnections: Assessing evidence, knowledge and practice in responses to rape

Prepared for the Government Equalities Office Stern Review by

Professor Jennifer Brown, London School of Economics

Dr Miranda Horvath, University of Surrey

Professor Liz Kelly, London Metropolitan University

Dr Nicole Westmarland, Durham University

April 2010

Contents

1. Introduction, policy context and method	3
1.1 Introduction	3
1.2 The policy context	3
1.3 Recent changes and innovations	4
1.4 Research and evaluation	5
1.5 Methodological approach	6
2. The prevalence and distribution of rape in society	8
2.1 Definitions and problems in reporting rates	8
2.2 Prevalence research findings	9
2.3 Profile of victim-survivors and risk factors	11
3. Reporting and disclosure	12
3.1 Non-reporting	12
3.2 Reporting rates and police recorded rapes	14
3.2.1 Reporting rates	14
3.2.2 Police recording rates	16
4. Support and advocacy	17
4.1 Definitions	17
4.2 What represents good support and advocacy for victim-survivors?	18
4.2.1 Coping	18
4.2.2 Specialist support services	19
4.2.3 Advocacy	20
4.2.4 Secondary victimisation	20
4.2.5 Expanded justice alternatives	21
4.3 Support and third party reporting	22
4.4 The impact of the introduction of Independent Sexual Violence Advisors	22
4.5 Victim-survivor 'satisfaction', expectations and outcomes	23
5. Criminal justice system responses	25
5.1 Criminal justice system professionals	25
5.2 Attrition studies	25
5.3 The court experience for victim-survivors	27
5.4 Victim 'satisfaction' with the criminal justice system	28

5.5	Conviction rates	29
5.6	Prosecution rates	29
5.7	Returning guilty verdicts	30
6.	Response of the health system	33
6.1	Sexual assault referral centres	33
6.1.1	Criminal justice outcomes	34
6.2	Forensic medical examinations	35
6.2.1	Victim-survivor experiences	35
6.2.2	Criminal justice outcomes	35
6.2.3	Gender of examiner	36
6.3	Other healthcare responses	37
6.4	Counselling	37
6.5	What a good outcome looks like	38
7.	Attitudes to and stereotypes of rape	39
7.1	Police attitudes	39
7.2	Healthcare professionals' attitudes	40
7.3	General population attitudes	41
8.	Impact of legal and policy changes	43
8.1	Legislative changes	43
8.1.1	Sexual Offences Act 2003	43
8.1.2	Rape shield legislation	43
8.1.3	Special measures	44
8.2	Impact of policy changes	45
8.3	Other recent interventions	46
8.3.1	The potential impact of proposed interventions	46
9.	Short wins and long hauls	48
9.1	Immediate short wins	48
9.2	Intermediate short wins	48
9.3	Long hauls	49
	References	51

I. Introduction, policy context and method

I.1 Introduction

This research review was commissioned as part of the Stern Review of responses by public bodies to rape. The terms of reference included a series of 31 questions about the extent to which there was research evidence on key policy issues, including evidence of the effectiveness of recent legislative and practice changes in England and Wales. The time scale precluded a full systematic literature review and so an adapted Rapid Evidence Assessment (REA) methodology was utilised following the guidance provided in the Government Social Research Unit's REA toolkit. As is frequently the case, the research and policy agendas do not readily map onto one another in clear and consistent ways so it was not possible to fully address all the questions posed.

This document summarises a much longer report structured in terms of the specific questions the review was asked to address and assessing the strength of evidence currently available. Here the findings are presented through a set of key themes:

- what we know about the prevalence and distribution of rape;
- reporting and disclosure;
- support and advocacy;
- the response of the criminal justice system;
- the response of the health system;
- attitudes to and stereotypes of rape; and
- the impact of recent policy changes.

We conclude with some possible future directions which flow from this evidence base. The findings are located within a summary of the current policy context and the methodological approach used to access the material used.

I.2 The policy context

The Stern Review was announced on 22 September 2009 by the Government Equalities Office (GEO). Led by Baroness Vivien Stern, the review's brief was to examine how public authorities (including the police, local authorities, healthcare providers, the Crown Prosecution Service (CPS) and non-governmental organisations) respond to, and interact with each other in respect of, rape complaints. As well as commissioning this research review and an empirical study about opinions on rape (Brown et al., 2010), Baroness Stern heard evidence from a range of sources, including an

internet survey with organisations and members of the public, focus groups with victim-survivors¹ and 11 regional visits with key stakeholders.

The Stern Review follows a decade of attention paid to the high attrition rate in rape cases (i.e. the failure of cases to proceed at various stages throughout the criminal justice system (CJS)) and several recent high-profile cases which raised concerns about the quality of early responses to complaints by the Metropolitan Police Service (i.e. the Worboys and Reid cases).² It also takes place within the context of the first integrated approach to violence against women and girls from the Westminster Government (HM Government, 2009), the report on the views of rape victim-survivors led by Victims' Champion Sara Payne (Payne, 2009), the Department of Health Taskforce on the Health Aspects of Violence Against Women and Children led by Professor Sir George Alberti and the review into the sexualisation of young people led by Dr Linda Papadopoulos (Papadopoulos, 2010).

1.3 Recent changes and innovations

During the decade preceding the Stern Review, a number of significant legal and policy changes were instituted:

- the Youth Justice and Criminal Evidence Act 1999, restricting sexual history evidence and introducing special measures to enable victim/witnesses to give best evidence;
- Multi-Agency Public Protection Arrangements (MAPPA) supporting the assessment and management of the most serious sexual and violent offenders in 2001;

¹ This concept is used to acknowledge both the fact of victimisation and the agency that individuals exercise in coping at the time and subsequently with sexual violence. While this concept is not gendered, and includes men who are raped, at various places we do refer to women – either because the research referred to focused only on them or to recognise that current evidence shows that they are the vast majority of victim-survivors.

² John Worboys and Kirk Reid were both convicted of separate series' of sexual assaults in 2009, with judges making comments on poor investigation. The cases were referred to the Independent Police Complaints Commission which found that the Metropolitan Police Service (MPS) missed investigative opportunities in the Worboys case. In the Reid case, the MPS took the unprecedented step of apologising to victims for the failure to detect him earlier.

- the first Her Majesty's Crown Prosecution Service Inspectorate/Her Majesty's Inspectorate of Constabulary (HMCPSI/HMIC) report on the processing of rape complaints in 2002, with its 18 recommendations, followed by a Rape Action Plan, beginning a new policy focus;
- the Sexual Offences Act 2003 which modernised sexual offences law;
- CPS guidance on prosecuting rape, 2004, revised 2009;
- Department of Health/National Institute for Mental Health in England (DH/NIMHE) Victims of Violence and Abuse Prevention Programme, 2004–07;
- Association of Chief Police Officers (ACPO) guidance on investigating rape, 2005;
- the CPS Directorate for Sexual Offences Team, 2005;
- expansion of sexual assault referral centres (SARCs);
- the use of Victims Fund and GEO 'Special Fund' monies to secure rape crisis provision;
- introduction of Independent Sexual Violence Advisors (ISVAs);
- cross-government action plan on sexual violence and abuse, 2007;
- compulsory training for all rape specialist prosecutors from 2008; and
- joint ACPO/CPS protocol, 2009.

1.4 Research and evaluation

These policy innovations were accompanied by an increase in research on sexual violence, with particular attention paid to attrition and evaluation of SARCs. Despite these efforts, directed towards improving and making more consistent responses to victim-survivors, this review will show that the picture has not changed substantially over the decade and that too many of the recommendations made in research and by previous inquiries and audits have not been consistently implemented. HMCPSI/HMIC (2002) themselves conclude:

... it is not necessarily about changing what is done, but ensuring instead that what is done is effective and is carried out to a consistently high standard and that the efforts of all of those involved are properly supported and co-ordinated. In many respects policies are sound and in place. It is not a question of changing the approach, but of ensuring that what should be done is actually done in practice. (p.5)

This view was re-affirmed some seven years later by Assistant Commissioner John Yates, at the time ACPO rape lead, who commented:

Put simply, there are too many and significant inconsistencies in the investigative response at every level. This is not only in London, but throughout England and Wales. National inspections by Her Majesty's Inspectorate of Constabulary have come and gone. Straightforward recommendations have been picked up and run with by some but not all forces. The policies are there, the training is in place but they are not embedded. **We are policy-rich and implementation-poor.** That is not to say that many individual cases are not dealt with expertly, sympathetically and professionally and receive proper and just outcomes, but no chief constable can be confident that every case is dealt with in this way. (*Guardian*, 26 March 2009, emphasis added)

1.5 Methodological approach

This was a question-led adapted REA, conducted to synthesise the available research evidence as comprehensively as possible. Given the constraints of the timetable, a full systematic review was not possible. The questions were set by GEO and informed the search criteria. Nine online abstracting databases were searched for academic publications, using 60 search terms. Given the focus on current policy, searches were limited to the last 15 years (1995–2010) and restricted to countries with common law legal systems. Exceptions to this were: key events; areas where there was thin coverage; specifications made in the brief. The unpublished and/or non-peer-reviewed research (often referred to as 'grey' literature) was accessed through several routes:

- research review team members sent requests to their extended networks of researchers and practitioners requesting relevant material;
- current holdings by researchers were drawn on;
- GEO forwarded any information it received from its call for evidence; and
- web searches were conducted through Google using the same terms as the database searches and the first 50 hits from each search term investigated.

Once material had been located, references were coded as high relevance, not directly relevant and not relevant to the present review. Classification took into account the provenance of the source, peer-reviewed being the most highly regarded and reports by established researchers or formal investigations being the next tier of acceptable quality as evidence. Attempts were made to locate the highly relevant material, largely through our university libraries and document requests to the British Library.

While there was considerable coverage of rape and sexual assault generally (although far less than for domestic violence, which was included in some searches), the specific areas the review was asked to address were not all strongly evidenced. Far more research was found about the impact of rape and sexual assault than on intervention outcomes. In particular there was very little evaluative work of new policies or procedures that have been introduced. There was also little on the effectiveness of support, advocacy and health interventions in England and Wales. Where strong evidence from other common law jurisdictions was found, this has been drawn on.

2. The prevalence and distribution of rape in society

2.1 Definitions and problems in reporting rates

We were asked to look at the evidence on the prevalence and distribution of rape, outlining trends and possible reasons for variations. Research assessing the extent of rape in populations is done through random sample surveys. The most accurate are considered to be those which address either sexual violence specifically or violence against women surveys (Walby, 2005). Neither, however, has been conducted in the UK over the last 15 years, although a specialist sexual violence survey, *The SAVI Report*, was undertaken in Ireland (McGee et al., 2002). The most up-to-date data for England and Wales therefore comes from a special module included in the British Crime Survey (BCS). However, there are limitations to victimisation surveys such as the BCS, including the truncated age of respondents (over 16 and less than 60 years of age) and the omission of particularly vulnerable groups such as the homeless and institutionalised.

Prevalence research methodology has been a topic of considerable international attention and debate, with no internationally agreed good practice and competing approaches. How the survey is framed, in terms of crime, victimisation or health, affects the extent to which individuals think their experiences are relevant, alongside the number and wording of questions also affecting response rates (Johnson, Ollus and Nevala, 2008; Martinez et al., 2007). It is also recognised that there has been less attention paid to sexual violence than domestic violence in survey design and content (Hagemann-White 2001; Johnson, Ollus and Nevala, 2008).

One specific problem which research must contend with is what Koss (1985) defined as 'unacknowledged rape'. This covers both those who report a sexual assault that legally constitutes rape, but do not define themselves as victims of rape (rates in surveys range between 43% and 73% (Myhill and Allen, 2002; Peterson and Muehlenhard, 2004)) and experiences of non-consensual sex which are not even reported in surveys as the experiences are 'normalised'.

Box 1: Reasons why survey respondents may not acknowledge coerced sex as rape

- They do not want to view themselves as rape victims because this connotes powerlessness and/or stigma.
- They do not want to view the perpetrator, often an intimate partner, as a rapist.
- They are influenced by rape myths.
- They do not have the emotional reactions they believe consistent with rape.
- They view non-consensual sex as unwanted sex.

(Peterson and Muehlenhard, 2004)

The goal of increasing reporting – to surveys, informal networks, support services and to the police – is revealed here to be linked to public awareness-raising as stereotypes of rape affect the extent to which individuals place their own experiences within the concept. For those whose first language is not English, the situation is even more complex as the concepts of ‘rape’, ‘forced sex’ or ‘non-consensual sex’ may literally not exist (see Gill, 2009; Pande, 2009 for Asian languages). Interventions that encourage and enable women to name their experiences are indicated by this data, and supported by the fact that many calls to rape crisis helplines begin with the statement, ‘I don’t know if I am ringing the right place, but...’

2.2 Prevalence research findings

Prevalence is generally calculated either as a lifetime, since age 16, or as last 12-month proportion of the population. The BCS measures self-reported victimisation across a range of different crime types on an annual basis. Rape is part of a self-completion module on interpersonal violence.

Box 2: Prevalence estimate 2007/08

- One in four women (23.3%) and one in thirty-three men (3%) men had experienced some form of sexual assault (including attempts) since the age of 16.
- For rape (including attempts) the prevalence was nearly one in twenty women (4.6%) and one in two hundred men (0.5%) since the age of 16.

(Povey et al., 2009)

However, there is a range of reasons why the BCS underestimates rape prevalence, including the fact that the questions are framed within the context of a 'crime' survey, that respondents are not asked about victimisation before they were aged 16 and that some populations that may have high levels of victimisation, including students and the homeless, are excluded.

Specialist sexual violence surveys invariably find higher prevalence rates than more generic studies. For example, in Ireland the SAVI research (McGee et al., 2002) found that:

- one in five women and one in six men experienced contact sexual abuse in childhood;
- one in ten women and one in fourteen men reported non-contact abuse;
- in adulthood, one in five women and one in ten men experienced contact sexual assault; and
- for lifetime prevalence, this equated to more than four in ten women (42%) and over a quarter of men (28%) for any form of sexual abuse or assault, and 10% of women and 3% of men for penetrative abuse.

There are no obvious reasons why rates of sexual violence should be higher in Ireland than in England and Wales. Further evidence of a higher rape prevalence rate than that found by the BCS can be seen in the study by Painter (1991), one of the few specific to sexual violence in the UK focusing primarily on rape in marriage, which found that one in four women in the UK had experienced rape or an attempted rape as adults.

The evidence base on the extent of sexual violence in England and Wales cannot, in light of the above discussion, be considered strong and consideration should be given to further refinement of the BCS methodology and a replication of the SAVI survey.

2.3 Profile of victim-survivors and risk factors

With the proviso that the current data is not strong, BCS findings suggest that rape is associated with gender, age and relationship to the perpetrator. Note that 'reporting' here refers to those completing the survey, not those making a formal police report.

- Over 90% of those reporting rape are female.
- The age groups most at risk are young women aged 16–24 and the 24–44 age group, the latter being most likely to report rape by a partner.
- The vast majority of perpetrators are known men, with BCS data finding more than half (53%) were current and ex-partners. Other studies have found a somewhat lower figure, which may be accounted for by the fact that the BCS asks a series of questions about intimate partner violence, thus acting as a 'prompt' to reporting partner rape.
- Single, separated and divorced women are more likely to report rape but this may be simply reflecting the fact that young women are more likely to be single, and those who have experienced rape by a partner are more likely to have ended the relationship.
- Stranger rapes are a minority of cases, at just over 10%.

Contexts are also relevant here, with re-analysis of two data sets (Lovett and Horvath, 2009), one from SARCs and one from police reports, showing that most rapes occur in the social arena and private space (most commonly the homes of victim-survivors or offenders); that is, locations in which women and men engage in routine and everyday activities.

This profile was not, traditionally, reflected in the rapes that are reported to the police, which included a higher proportion of stranger assaults; the profiles have moved closer to one another in the last decade (Lovett and Kelly, 2009).

3. Reporting and disclosure

We were asked to examine the evidence on reporting of rape, including consideration of the impact of the differences between legal and commonsense definitions of rape and how these affect the handling of rape complaints. A fairly strong evidence base was identified for the definitions of rape and the phenomenon of unreported rape but only limited information is available on the characteristics of those not reporting.

3.1 Non-reporting

Rape is a violation of people and relationships (Koss, 2006) and to be any kind of victim, but accentuated with sexual violence, is a stigmatised identity, with additional (and potentially dangerous) meanings within some cultural/religious communities. This makes telling anyone a risk; what victim-survivors are seeking when they do tell is validation of the harm they have suffered (ibid.), beyond this their specific goals will vary according to who they tell and at what point. The potential costs of telling someone include: loss of privacy; disapproval; economic pressures; not being believed; stress and anxiety; and risks to personal safety.

Not naming or defining an experience as sexual violence has policy-relevant consequences. Clements and Ogle (2009) report on and replicate the strong finding that the health impacts of sexual violence are greater for unacknowledged victim-survivors. Previous research has also noted that telling someone is often a route to reporting and/or accessing support (see, e.g., Lovett, Regan and Kelly, 2004). The most recent British Crime Survey (BCS) data (Povey et al., 2009) shows that a significant minority of victim-survivors had not told anyone about their most recent experience of serious sexual assault, and only a small minority had told the police.

- Two-fifths (40%) told no one about their experience.
- While men and women were equally likely to tell someone, who they told varied somewhat.
- Of those who did tell, the most common confidantes were friends, relatives or neighbours (44%) (see also, Kelly (2002), for previous similar research findings).

While reporting is a key issue with respect to the criminal justice system (CJS), access to support is more an issue of disclosure; telling someone who is in a position to help. Some studies address this through the concept of help-seeking. Several studies have found that help-seeking is low among victim-survivors (Amstader et al., 2008; Nasta et al., 2005).

Golding et al. (1989) undertaking secondary analysis of population surveys (n=9,855), found that social support was lower among those who have suffered sexual violence. One explanation, offered by Kaukinen and Demaris (2009), is that help-seeking is paradoxical, with both positive and negative responses possible. There is strong evidence that there are disincentives to telling, especially where the offender is known, the assault was not stereotypical and where there was involvement of alcohol (Ullman et al., 2008). Black, Asian and minority ethnic women are also less likely to tell anyone (ibid.; Gill, 2009).

A critical role, therefore, for professionals and agencies is to make sexual violence 'speakable' (Hooper and Warwick, 2006), including the creation of safe spaces in which disclosure is not only possible but affirmed (Campbell et al., 2004). This is facilitated through normalising experience; connection; support; help; and respect (ibid.). The focus groups conducted by Sara Payne (2009) confirm that victim-survivors seek to be treated with dignity and respect, and had strong preferences for specialised women's support services and female practitioners.

The evidence summarised above accounts for the fact that rape is one of the most under-reported crimes in many jurisdictions (Jordan 2004, 2008b; Kelly, Lovett and Regan, 2005; US Department of Justice, 2002). HMCPSP/HMIC (2002) estimates between 75% and 95% of victim-survivors never report their rape to police in England and Wales. Rates of under-reporting vary but Daly and Bouhours (in press) estimate an average of four in five (86%) victim-survivors across five common law jurisdictions, which include England and Wales, choose not to make an official complaint. This comparative study shows that the percentage of those who choose to report ranges between 6% and 32%, with England and Wales at the international average of 14%. The most recent BCS data (Povey et al., 2009) is fairly consistent with this, with 11% making a police report about their most recent experience of serious sexual assault. This is the same level as in the 2005/06 BCS data, suggesting no increase in likelihood to report over the most recent time scale. Reasons for not reporting rape are summarised by Kelly and colleagues and shown in Box 3.

Box 3: Reasons for not reporting rape

Personal

- Relatedness (loyalty to someone known to the victim)
- Feelings of shame/embarrassment
- Fear of further attack/retaliation
- Belief about own culpability
- Demographic vulnerability (age, class, education, ethnicity)
- Psychological vulnerability (mental health, learning difficulties)

Criminal justice system

- Beliefs about police ill-treatment of victims
- Expectation of ill-treatment
- Lack of confidence about being believed
- Fear of court proceedings

(Kelly, Lovett and Regan, 2005)

The Independent Police Complaints Commission (2010) inquiry revealed that the rapist John Worboys claimed he had won money and would often show passengers in his taxi a bag of money and offer them a glass of champagne, which had been previously mixed with substances. He would then sexually assault his unconscious passenger. His victim-survivors were often unsure about what had occurred to them during the journey, and many did not report the matter to the police. Indeed, of the 80-plus victims to contact the police after the arrest of Worboys, over 60 had not reported the incident to the police at the time.

3.2 Reporting rates and police recorded rapes

3.2.1 Reporting rates

Reporting rates are calculated as a proportion of the population, usually per 100,000. Daly and Bouhours (in press) found that, for England and Wales, between 1981 and 2006 reporting for all penetrative offences (rape and unlawful sexual intercourse) and non-penetrative offences (indecent assault) increased over time, more specifically:

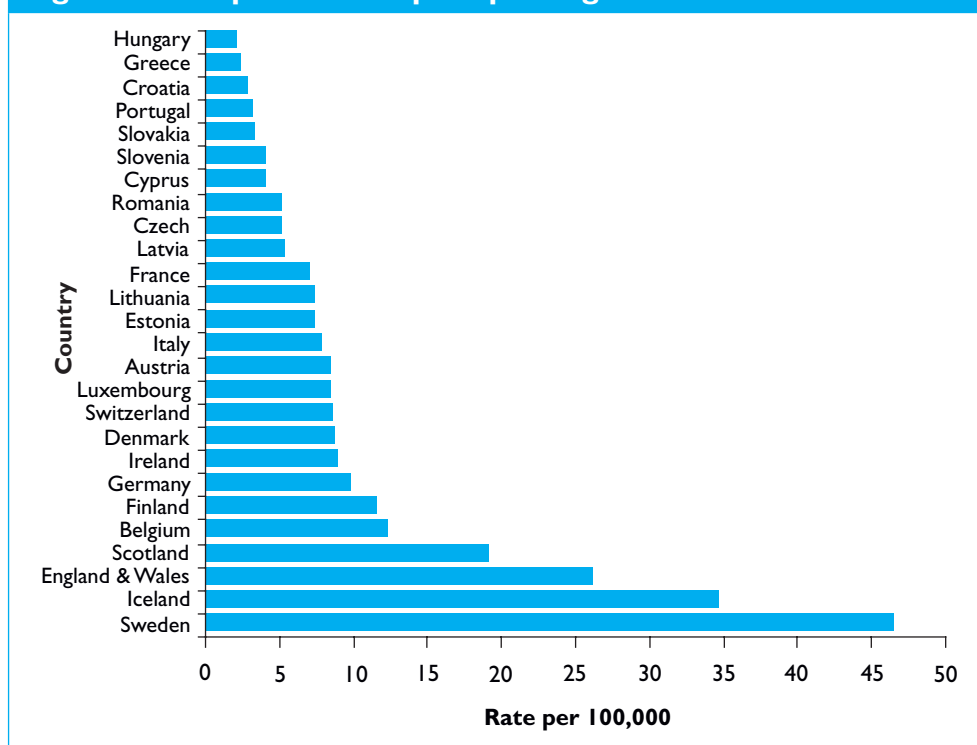
During the 1980s and to the mid 1990s, while there were steady increases each year in reported sexual assault, from 1996 to the present, the rate of increase has grown substantially (53% rate of increase from 1996 to the present). (p.12)

Similar calculations were made comparatively across Europe, using reported rape figures and national population data (Lovett and Kelly, 2009).³ Taking 2006 as the base year, England and Wales had the third highest reporting rate (see Figure 1). The European results may be interpreted in a number of ways:

- victim-survivors in England and Wales, Iceland and Sweden are more likely to report rape;
- the police in these countries record reported sexual violence more consistently;
- there are differential incidence rates across Europe.

We currently lack evidence on which of these factors, singly or in combination, are explanatory.

Figure 1: Europe – 2006 rape reporting rates



³ The difference between this and Daly and Bouhours' findings is probably due to the fact that the latter combined rape and sexual assault and used a different set of comparator countries.

3.2.2 Police recording rates

In 2008/09 there were 12,165 rapes of a female (an increase of 5% compared with 2007/08) and 968 rapes of a male (a decrease of 4%) recorded by the police in England and Wales (Roe, Coleman and Kaiza, 2009). The two previous years (2006–08) had seen a substantial decrease in reported rapes for both females and males (8% for females and 13% for males (Hoare and Povey, 2008)). It is not clear why this should be the case, although the decline did coincide with the monitoring of responses to rape by the Home Office. It is widely accepted that recorded crime rates may also be distorted by changes in police recording practices (ibid.). Other possible explanations might be a decline in confidence among victim-survivors and changes in the incidence of rape; however, these seem less likely explanations given the increase in the most recent data.

Critically important factors to improving rates of reporting and collection of evidence to allow cases to proceed were suggested by Jan Jordan in the New Zealand context, but which are also relevant for the UK.

Box 4: Recommendations to improve reporting of rape to police

- Complainant to be believed and seen as a person with an individual crime experience.
- Proper support and the establishment of a good relation with the victim-survivor.
- Location of interviews and medical examinations.
- Continuity of contact.
- Reassurance, safety and privacy.

(Jordan, 2008b)

4. Support and advocacy

4.1 Definitions

We were asked to look at evidence on good practice and good outcomes in terms of support and advocacy, including consideration of the impact of specific issues, third party reporting and the introduction of Independent Sexual Violence Advisors (ISVAs). We address this before the responses of the criminal justice system (CJS) and health system, despite overlaps, in recognition of the fact that the majority of victim-survivors do not make official reports, but do tell someone and seek support.

Searches demonstrated limited research on advocacy and support with respect to sexual violence outside the USA. The research which has been undertaken is often associated with institutional interventions, especially those of sexual assault referral centres (SARCs) and Rape Crisis Centres (RCCs), albeit that there are some studies which draw on wider community samples. There is a dearth of longitudinal studies which follow victim-survivors after interventions,⁴ or through the process of coping which can have a number of phases.

The terms 'support' and 'advocacy' are broad ones and are defined in Box 5.

Box 5: Definitions of support and advocacy

'Support' can be formal (from organisations) or informal (from others in one's network – friends, kin, communities) and includes all resources which enable making sense and coping positively with challenging issues.

It can take a number of forms: instrumental – being helped with a specific problem/issue; practical – tangible forms of assistance, which can be financial, child care; informational – giving knowledge and advice; and emotional – providing recognition and reassurance.

'Advocacy' has traditionally been defined as proactive interventions which ensure that rights are realised and can be individual or system based.

In this review, 'support' refers to both formal and informal support. The forms listed in the box above are not mutually exclusive and may be provided by the same person or service. 'Advocacy' is not a type of service provision, but an engagement between service users and service providers to improve responses. In recent public policy in England and

⁴ A ten-year study in Canada under the leadership of Jane Ursel is currently in its fifth wave of data collection.

Wales, advocacy has become identified with Independent Domestic Violence Advisors (IDVAs) and ISVAs, and both roles draw on the above understanding of advocacy, but with an arguably narrower focus on CJS processes and outcomes.

4.2 What represents good support and advocacy for victim-survivors?

There is quite strong evidence across a range of studies on the basic elements of what could be defined as good outcomes from the perspective of victim-survivors: being believed and acknowledged; access to information and options; complete medical care; feeling in control of what happens to their body and case; and access to specialist services, including practical and emotional support; access to female practitioners (Ahrens, 2006; Chowdhury-Hawkins et al., 2008; Jordan, 2009; Schonbucher, Kelly and Horvath, 2009; Schumm, Briggs-Philips and Hobfoll, 2006). Given that it is the role of an advocate to promote the needs and rights of service users, we can therefore extrapolate that they should endeavour to maximise these outcomes.

4.2.1 Coping

There is also strong evidence that what is termed ‘avoidant coping’, i.e. not talking to anyone, not seeking help, attempting to forget what happened, is associated with higher negative impacts, including self-blame. This appears to create a vicious circle with those who blame themselves more receiving less support when they do tell (Ullman and Filipas, 2001). The alternative, ‘approach coping’, is facilitated by social support; in a rare study, which followed victim-survivors (n=171) for 12 months, perception of being in control was the most important mediating variable (Littleton et al., 2006). Another study, involving 777 women screened in an obstetrics/gynaecology context, supports this, finding cumulative impacts associated with multiple victimisation; however, those with greater social support had less severe impacts (Schumm, Briggs-Philips and Hobfoll, 2006). The fact that telling someone is not sufficient to undo harms is confirmed by a qualitative study (Ahrens, 2006) documenting three routes through which disclosure can result in withdrawal into silence: a negative response from professionals, producing a sense that there is no point in seeking help; a negative response from family and friends, which increases self-blame; and a negative response from either, which leads to a questioning of whether the event was a sexual assault. Where those who are told are unresponsive to the needs of victim-survivors, this decreases their options and their access to support. One key indicator of good outcomes is, therefore, responsiveness (Koss, 2006).

4.2.2 Specialist support services

Campbell and Martin (2001) note that there are very few studies that assess what benefits victim-survivors (see also, Campbell and Wasco, 2005; Lonsway, Archambault and Lisak, 2009). This has begun to shift with a series of studies by Rebecca Campbell, Sara Ullman and their colleagues on responses in the USA, and a series of evaluations of SARCs in the UK (Lovett, Regan and Kelly, 2004; Regan, Kelly and Lovett, 2008; Robinson, 2009; Schonbucher et al., 2009). Campbell (2008), in an overview, notes the consistent finding that where there is no specialist provision many victim-survivors experience 'secondary victimisation' and poor practice: the majority of reported cases are not prosecuted; many do not receive complete medical care; and most do not have access to quality mental health or support services. Specialisation is also associated with increased service use: Sampsel et al. (2009) report on the introduction of specialisation in a hospital emergency room, which within a year doubled the number of cases seen.

Access to specialist services is, however, limited by under-resourcing of sexual violence services in the UK (Women's Resource Centre and Rape Crisis, 2008; Coy, Kelly and Foord, 2009), and also noted in the USA (Macy et al., 2010) and Australia (National Council to Reduce Violence Against Women and Children, 2009). In each case insufficient funding is recognised as the reason services do not have the capacity to meet needs.

A recent New Zealand study (Kingi and Jordan, 2009), involving 75 victim-survivors, sought to trace what had been helpful and enabled 'recovery'. Three-quarters had told someone within a week, most commonly a friend or family member, seeking recognition, support and advice. Most had had contact with a formal support service but a third noted difficulty accessing support when, and for as long as, they needed it. Emotional support was the most valued, and specialist sexual violence agencies were overwhelmingly appreciated. Two-thirds received significant emotional and practical support from informal network members, albeit friends and family often lacked skills and knowledge, with only a small minority receiving negative responses. Many also drew on self-help, including books and exercise, to complement support from others. Kingi and Jordan conclude that while sexual violence had profound impacts on self and identity for this group, 'rebuilding their selves' was frequently a combination of formal and informal support complemented by self-help (p.xxii).

4.2.3 Advocacy

US research on advocacy has strengthened the evidence base through comparing women who have and have not accessed services, while also exploring the limits and potentials of system change. Campbell and Raja (1999) recruited 102 victim-survivors through community contexts. While only a fifth had had access to a specialist sexual violence advocate, when compared with women who had no access, they had decreased levels of distress, especially where the perpetrator was known. A later project (Campbell, 2006) compared 36 victim-survivors who were seen at a hospital with advocates⁵ with 45 attending hospitals where there was none. Statistical modelling showed that the presence and interventions of advocates resulted in:

- increased reports to police;
- fewer negative responses to victim-survivors by police;
- less distress at the legal process;
- increased access to medical services; and
- fewer reports of negative interactions with medical staff.

4.2.4 Secondary victimisation

Campbell (2006) notes that, in the USA, RCCs provide the majority of advocates for hospital-based sexual assault nurse examiner (SANE) programmes,⁶ and argues that their role is not to improve services but to prevent secondary victimisation. This argument is supported by data from previous studies showing that the majority of victim-survivors felt 'depressed, guilty, anxious, distrustful and reluctant to seek further support' after dealings with the legal system (Campbell et al., 2001) and most felt 'violated, depressed and anxious' after contact with medical staff (ibid.). Advocates make a difference by ameliorating such responses in the first instance in individual cases, and as they become embedded they use system advocacy to change the practices of the CJS and medical staff more generally. Ullman and Townsend (2007) are less sanguine about system advocacy. Their interviews with 25 experienced advocates revealed substantial barriers to wider change, the three most important of

⁵ In the USA there are a number of models of advocates attending where sexual assault is reported to police/hospitals – in some the advocates are connected to SANE programmes, in others they are rape crisis workers/volunteers who are on call.

⁶ Sexual assault nurse examiners provide the kind of services provided by SARCs in the UK; they may be based in a specific hospital or provide services to a group of hospitals.

which were: resources; environmental factors; and status issues between professionals.

Maier (2007) interviewed 47 advocates, noting Ullman's finding that victim-survivors are more likely to encounter negative responses from professionals than from informal network members. The key theme that emerged here was that the loss of control which is inherent in sexual assault itself may be replicated (this is known as 'secondary victimisation') through agency responses, especially those of police and medical staff (p.767). The presence of advocates was viewed as restoring some control to victim-survivors. Good practice in SARCs, especially in the conduct of forensic examinations, through explaining each step and asking permission for each element of the process, also points to the critical importance of restoring control to victim-survivors (Lovett, Regan and Kelly, 2004; Schonbucher, Kelly and Horvath, 2009).

4.2.5 Expanded justice alternatives

Probably the most contentious issue with respect to advocacy has been that raised by Mary Koss (2006) in the USA and Kathleen Daly (Daly and Stubbs, 2006) in Australia. After three decades of research on rape, both Koss and Daly have become advocates for 'expanded justice alternatives', arguing that tightly defined forms of restorative justice should complement criminal prosecution, as it can deliver some of what some victim-survivors want, especially control and voice. Advocates play key roles in restorative justice processes, and 15 organisations were interviewed (Curtis Fawley and Daly, 2005) resulting in a mixture of views on the potential positive and negative outcomes for victim-survivors: the opportunity to have one's story heard and recognised and to see the offender take responsibility were considered potential good outcomes, counter-balanced by concern that this might become a form of 'cheap justice' and increase the possibility of re-victimisation. This is a contested arena within violence against women research and practice communities (see Van Wormer (2009) for an overview and Cossins (2008)). There are contributors who warn against romanticising these processes in indigenous communities, where they can, and have been documented to, reinforce male and community control of women or compromise the treatment of serious offences because of the apparent leniency of offender outcomes in restorative justice approaches. While evidence in the youth justice field is increasingly positive, there is, as yet, limited evidence on the efficacy of such responses with respect to sexual violence, since there has been a relatively low take-up of the

demonstration projects. Daly and Bouhours (in press) conclude in their review of practices in five common law jurisdictions that:

Restorative justice conferences as a supplement to court sentencing or as a pre-sentence activity, post-guilty plea or part of a guilty plea could give victims a greater opportunity to describe the impact of an offence and for others to check the denials of wrong-doing. Again many people do not like this idea. Indeed, except for New Zealand and ad hoc practices in South Australia, all governments have ruled sexual offences ineligible for adult pre-sentence conferences.

Daly (2009) argues for a radical agenda with three elements: increasing early admission, reducing the need for fact-finding trials and minimising the hyper-stigmatisation of sex offending and offenders.

4.3 Support and third party reporting

There is little evidence with respect to third party reporting, although studies in the UK (Kelly, Lovett and Regan, 2005) and New Zealand (Jordan, 2004) note that it occurs in a small proportion of cases.

4.4 The impact of the introduction of Independent Sexual Violence Advisors

There is one evaluation of ISVAs to date, which focuses primarily on process rather than impact or outcomes (Robinson, 2009). It notes that ISVAs were intended to provide flexible, practical and proactive tailored assistance and advice in the aftermath of recent assault. Using six case studies, the research examines ISVAs located in SARCs and voluntary sector organisations, with both models found to have strengths and weaknesses. SARCs had higher case loads, but there was substantial missing data on the extent of future contacts and outcomes, compared with the voluntary sector organisations. For victim-survivors, ISVAs dealt effectively with their emotional concerns and provided valued practical assistance, including all the information they needed on legal processes – the lack of which has been a common complaint in previous research on criminal justice responses (see Kelly (2002) for an overview). At the system level there were concerns that ISVA training was not appropriate; concerns about the extent of independence where ISVAs are located in a SARC; and concern that sexual violence is yet to be integrated into multi-agency partnerships. The study concluded that ISVAs should be located in specialised sexual violence services and that both models should be supported, and it concurs with Lovett, Regan and Kelly (2004) that advocates can be expected to have only limited impact on attrition.

4.5 Victim-survivor 'satisfaction', expectations and outcomes

There has been limited research on this topic but a strong theme across the literature, and across locations, is that when asked to evaluate which services were the most helpful and their levels of satisfaction, specialist sexual violence services and RCCs in particular score the highest (see Fry (2007) for the USA; Kingi and Jordan (2009) for New Zealand; Lievore, (2005) for Australia). Fry (2007) notes that in hospital-based systems satisfaction increased where services were clearly victim-survivor-centred, which given that majority are female must also be women-centred. Again, Rebecca Campbell has undertaken the most sustained research, including studying transformations in RCCs themselves over three decades. Drawing on a national random sample of 168 (Campbell, 1998), most had adapted from grassroots foundations, and continued to offer comprehensive services. Newer groups tended to prioritise service provision, whereas older ones reported a tension between service provision and social change work. Older and free-standing groups were more likely to continue social change work, including community-based prevention programmes.

Ullman and Townsend (2007) note that scarcity of resources limits development in RCCs, especially in ensuring access for under-served groups, ethnic minority and disabled women being referred to explicitly. They also note the limitations: advocates have far less power and status than the legal/medical staff, which makes system advocacy difficult (p.436). In their paper reference is made to an ongoing study based on 1,000 women recruited from the community who had experienced sexual assault: 16% had sought support from RCCs. Of these women, 79.3% found it helpful, a higher percentage than was found in any of the other ten formal and informal sources assessed.

RCCs have typically used volunteers, but there is dearth of research on this. In both the USA and Canada it is volunteers who do much of the advocacy work before and following forensic examinations and who answer helplines: Hellman and House (2006) found that the 62 volunteers in one RCC accounted for two-thirds of the 24-hour coverage, in a centre which responded to 413 rape exams and took 4,120 helpline calls. Regular training and support were found to be critical in retention and intention to stay. Several studies stress the importance of self-care and support for workers (Ullman and Townsend, 2007), with Wasco and Campbell (2002) arguing that RCC workers should undertake proactive strategies and use what they hear as a resource in providing support to other service users.

Jan Jordan's (2008a) study in which she interviewed 15 women, all victim-survivors of the same serial rapist in New Zealand, found that the interest of the police and prosecutors in the success of this case led them to institute a series of special processes through which the victim-survivors were supported and kept informed. Some of the investigative officers commented on what they learnt, confirming a truism from research in the 1980s: that the best treated complainant provides the best evidence. This 'Rolls-Royce' treatment has not, however, become routine practice (ibid.).

Victim-survivors seek to be seen and treated as whole persons (Kelly, Lovett and Regan, 2005). In her study of responses to rape in 22 Florida communities, Martin (2005) found that organisational goals, especially those in the legal and medical systems, often conflict with victim-survivor needs and, moreover, have been found to cause further harm (Campbell and Wasco, 2005). Only RCCs in this study were able to be uncompromisingly victim-survivor-centred.

5. Criminal justice system responses

5.1 Criminal justice system professionals

We were asked to examine the evidence on criminal justice responses to rape including: the specific challenges for investigating rape, the techniques that have been developed to try and overcome these and the impact of the court process on rape cases. Overall there was limited evidence available.

The criminal justice response to rape involves at minimum three institutions (police, prosecution and courts) and often more (forensic and health services, non-governmental organisations and others). There is not, therefore, a single response, but multiple responses, all of which are connected in complex feedback loops. It is also critical to pay attention to the actions of individuals and the orientations of agencies, which may or may not be harmonised. One critical feature for England and Wales is that the criminal justice system (CJS) is adversarial.

Despite efforts to sensitise a variety of personnel in the systems that respond to sexual violence, there is inherently some element of shame and degradation in the process; the justice system is adversarial by design. (Koss and Achilles, 2008, p.3)

5.2 Attrition studies

While the unique evidential requirements in rape attracted considerable attention in the 1970s and 1980s, more recent studies have focused on police responses, court cases or the attrition process more broadly. Assessing the last is made complex by the fact that the police record data by offence type but the Crown Prosecution Service (CPS) records by offender, and there is currently no technical route that allows tracking of cases across the police, CPS and court processes. Attrition studies have had, therefore, to track cases across the three systems by collecting data from each and matching the cases.

There are also issues about the metric that is used in calculations of conviction rates, making it essential that the numerators and denominators used in percentage calculations are specified, i.e. what base rate is used in the calculation. While independent attrition studies begin from all reported cases, police prefer to count from those that are 'crimed', and the CPS from those that are prosecuted. Williams and Stanko (2009) show that of 677 Metropolitan Police Service rape allegations they investigated, different conviction rates emerged depending on the denominator of the calculation: as a function of all allegations it was 5.3%, of cases 'crimed' it was 7.9%, of all arrested suspects it was 13.7% and of all charged suspects it was 31.3%.

Harris and Grace (1999) undertook the first contemporary attrition study; they identified key attrition points and noted a significant fall in the conviction rate between 1985 and 1997 from 24% to 9%, despite various legal reforms and policy initiatives. They identified a reduction in no criming rates; acquaintance rapes were the most likely to be no crimed, while those involving intimate partners were most likely to be 'no further actioned' (NFA).

This study was followed in 2002 by the first joint Her Majesty's Crown Prosecution Service Inspectorate/Her Majesty's Inspectorate of Constabulary (HMCPSI/HMIC) thematic inspection, the task of which was to analyse and assess the quality of investigations, decision making and prosecution of rape cases by police and crown prosecutors with a stated goal of discovering the reasons behind the declining conviction rate. It reported a falling rate of detections, wide variations in police and prosecution practice by locality and estimated that between 75% and 95% of victim-survivors never reported their rape to police. HMCPSI and HMIC made 18 recommendations, which were accepted by the Government and formed the spine of the first Rape Action Plan (Home Office et al., 2002). The findings were echoed by later studies (Feist et al., 2007; HMCPSI, 2007; Kelly, Lovett and Regan, 2005; Kershaw, Nicholas and Walker, 2008) and all concur that around three-quarters of cases fail to proceed beyond the police investigation stage.

While the actual number of convictions has increased steadily, this has failed to keep pace with the increase in reporting and the conviction rate reached an all-time low of 5.3% in 2005. The downward trend has been reversed, but the increase since that time is just over 1%. Table 1 compares findings across two case tracking studies: while the conviction rate is the same, fewer cases were detected, charged and prosecuted in the more recent study.

Table 1: Case tracking comparison, 1999 and 2007

Stages of process	Harris and Grace (1999) [n=483]	HMCPSI (2007) [n=573]
Crimed	75%	72%
Detected	64%	38%
Charged	31%	22%
Prosecuted	23%	20%
Convicted	6%	6%

The most recent data from the CPS (2009) shows a small increase (from 54.5% in 2006/07 to 57.7% in 2008/09) in convictions of cases coming to court. Over a third (38.1%) of unsuccessful cases were the result of acquittals, and a 3% decline in victim retractions is noted – coinciding with the introduction of Independent Sexual Violence Advisors (ISVAs). The improvements in CPS prosecution of sexual violence cases are less evident for rape (CPS, 2009). These national figures disguise the huge variations across police force areas, with conviction rates ranging from 1.6% to 18.1% (Fawcett Society, 2010). It is unclear at this point whether these represent differential practices in recording or responding to cases.

Bryant and Loader conducted a report in 2008 to examine the 42 police forces in England and Wales. They found that the tasks undertaken during rape investigations were very similar across forces. However there was considerable variation between forces at the key attrition points. Forces ranged between 6% and 23% in their no criming rates, 35 forces had detection rates of between 20% and 29%, five had rates of between 30% and 39% and the two top performers had rates just over 40%. Prosecution drops in CPS areas ranged from 6.7% to 33.3% and, in 35 areas, between 20% and 29% of cases failed to reach trial. Conviction rates, as a function of the numbers of cases reaching court, varied from 63% to 86%. The study concluded, however, that it was not possible to robustly establish the reasons for differential performance.

Explanations for high attrition early in the process have focused on two key issues: the salience of stereotypes of rape, including a belief that many reports are false causing police to hold a sceptical attitude to all reports (Kelly, Lovett and Regan, 2005); and routine pragmatic agency practices (Martin, 2005).

5.3 The court experience for victim-survivors

While there are fewer studies based on observing cases in court, those that have been conducted concur that victim-survivors find giving evidence gruelling at best; several studies based on court observations have documented the range of tactics used by defence counsel to cast doubt on their testimony (Renner, 2002). Box 6 describes some of the adversarial tactics used in rape cases.

Larcombe (2002) posited the notion of the ‘ideal’ victim, i.e. one of blameless character and conduct. In a contested consent case, it is the complainant’s refusal that is at issue. Defence counsel seeks to represent the complainant as failing to protect or regulate herself, her affairs and her

sexuality. It is through discrepancies between the behaviour and conduct of the complainant and those of the 'deserving' rape victim that complainants are often discredited.

In her review of Australian cases, Larcombe (2002) noted the varied range of cases brought to court, including complainants who had been drinking prior to the assault and defendants who were family friends or acquaintances. In other words the law recognised the broader, more complex range of social circumstances where rape occurs. So while the cases did not replicate stereotypes, Larcombe exposed devices used by defence counsel 'to make the complainant appear indecisive, inconsistent and incompetent'. Complainants are positioned so that all they can do is reject or deny a series of propositions put to them by defence lawyers, with their credibility as a witness dependent on an ability to resist the defence's construction of unreliability or contradiction. Larcombe argued that the witness's resistance to the defence counsel's imputations plays out to the jury behaviour, which makes her story of non-consensual and resistant responses to the accused's sexual propositions more persuasive. The jury will have seen her resist, or not resist, counsel's questioning.

Box 6: Adversarial tactics

- Asking the same question repeatedly in an increasingly louder voice, with little opportunity for the victim-survivor to respond (Kebbell, Deperez and Wagstaff, 2003).
- Use of a hostile tone, suggesting the allegation was false and calling the victim-survivor a 'time-waster' and 'liar' (Brown, Burman and Jamieson, 1993; Temkin, 2002).
- Testing the victim-survivor's credibility and consistency as a witness (Burman et al., 2007; Ellison and Munro, 2009b; Lees, 1996; Temkin, 2000, 2002).

(Burman, 2009)

5.4 Victim 'satisfaction' with the criminal justice system

Data on victim 'satisfaction' with the CJS response is both relatively weak and inconsistent. There are issues at all stages of the process depending on how individuals were treated, the decisions that were made and how these were communicated: these cover what are referred to as procedural and outcome justice. Myhill and Allen (2002), using British Crime Survey data, reported 32% being very satisfied with police response and 22% very

dissatisfied. More recent qualitative data from Sara Payne's report (2009), together with the focus groups undertaken by the Women's National Commission (WNC) (2009) as part of the consultation on the Violence Against Women Strategy, reveal dissatisfactions with prosecutors (see also Harris and Grace 1999; Kelly, Lovett and Regan, 2005) and a strong perception that defendants have more rights within the CJS. In contrast, one recent study reported that most victim-survivors were satisfied with the court process (Kebbell, O'Kelly and Gilchrist, 2007). Perhaps the most detailed accounts of how victim-survivors experience the court process come from Konradi (2001; 2007) who, through interviews with 54 women, identified that victim-survivors:

- recall the rape experience through the act of testifying;
- re-experience disempowerment upon encountering the defendant in court; and
- experience disempowerment through problematic interactions with defence lawyers.

Konradi also noted that other events led to intense victim-survivors experiencing intense negative emotions including shame, embarrassment, grief and anxiety which also caused physical discomfort. These included being unfamiliar with the criminal justice system and processes, and having friends, family members and the general public see and hear them talk about intimate violation.

5.5 Conviction rates

Critics of attrition research contend that these patterns are no worse for rape than other offences. Research, however, suggests otherwise: Daly and Bouhours (in press) found lower conviction rates for rape across several jurisdictions and Taylor (2007), with reference to Australia, reported that the percentage of defendants who plead not guilty and who are acquitted is highest for sexual assault compared with seven other offences. Ministry of Justice (2009) statistics for England and Wales show that, of cases being heard in Crown Court, rape cases consistently have the lowest convictions compared with other indictable offences. This is without factoring in that there will be a much higher rate of named suspects for rape than many other serious crimes, which tend to be committed by unknown persons.

5.6 Prosecution rates

The above data suggests that there may be particular challenges associated with investigating rape and potential routes that might increase procedural

justice. Studies from the USA and England and Wales have found that successful prosecution is associated with victim-survivors younger than 18, the presence of injuries and the use of a weapon by the assailant (Kelly, 2002; Kelly, Lovett and Regan, 2005). The USA also shows a trend towards conviction where the victim-survivor is white (Gray-Eurom, Seaberg and Wears, 2002). Case studies from the USA suggest sexual assault nurse examiner (SANE) programmes increase prosecution rates (e.g. Cornell, 1998; Hutson, 2002) and that when cases go to trial expert witness testimony from SANEs is instrumental in obtaining convictions (O'Brien, 1996). There are few strong empirical tests of these claims however. Exceptions include the study by Crandall and Helitzer (2003), which had a stronger methodological design than other studies of SANE support, but, overall, more direct comparisons between cases involving and not involving SANEs' evidence is needed (Campbell, Patterson and Lichty, 2005).

A recent Canadian study found that documentation of forensic samples was significantly associated with charges being filed but only severe injuries were significantly associated with conviction (McGregor, Du Mont and Myhr, 2002). Data from the European attrition study found forensic evidence was associated with prosecution and conviction (Lovett and Kelly, 2009).

All of these factors show a trend towards convictions being more likely where cases are closer to stereotypes of rape.

5.7 Returning guilty verdicts

In adversarial systems juries remain a crucial element of the court process. Jurors are members of the general public and, as such, hold pre-existing attitudes and beliefs that they bring with them into the courtroom. These influence their perceptions of the victim-survivor and how they interpret their testimony. There is a growing body of work on the impact of a range of factors on (largely mock) jurors' perceptions and judgements in rape trials, including:

- the gender of jurors (Taylor and Joudo, 2005);
- rape myth acceptance;
- sexism;
- stereotypes (ibid.);
- irrelevant information;
- victim-survivor/witness credibility – including alcohol/drug consumption and sexual history (Ellison and Munro, 2009a,b,c; Schuller and Klippenstine, 2004);

- emotions displayed (or not) by the victim-survivor/witness;
- socio-sexual scripts (Ellison and Munro, 2009a);
- instructions from the judge;
- forensic evidence (Jenkins and Schuller, 2007);
- pre-trial publicity; and
- ethnicity (Maxwell, Robinson and Post, 2003).

Broad conclusions that can be drawn from this array of studies are that multiple factors influence juror decision making and ways of controlling these influences are not yet well understood. Box 7 presents an overview of findings from these studies.

Box 7: Findings from mock jury studies

- Persistence of beliefs that a 'normal' reaction to a rape is to fight back.
- Social significance is attached to the offering of alcohol to a male companion, implying that sex might be on offer.
- Beliefs that the consumption of alcohol will sexually disinhibit a woman and she is thus more likely to enjoy being seduced.
- Belief that consenting to sex when drunk, which was then regretted, would more likely be retracted when sober.
- Women should take responsibility for any mixed signals given while drunk.
- Assaults by strangers are deemed more serious and traumatic.
- If sexual intercourse was not consensual there is an expectation of physical injuries.
- Where injuries were present mock jurors went to considerable lengths to find alternative explanations for them.
- The woman's behaviour prior to the assault (previous intimacy, consenting to kissing) was often relied upon to indicate reasonable belief in consent.
- Mock jurors tended to fill in the evidential gaps concerning the woman's previous sexual character and conjecture about her credibility.

Larcombe (2002) maintained that the successful rape complainant is not someone necessarily having an unblemished sexual history. Rather:

...she has to have a strong sense of herself and taking overt offence at (rather than being taken by surprise or accepting as all too familiar)

alternative and derogatory constructions of her character and credibility. She will need to be reasonably familiar with, and experienced in, managing power-loaded situations so that she can be polite but not compliant, co-operative but not submissive. She is not prone to exaggeration or embellishment but seems to talk straight. She answers questions quickly and precisely and speaks frankly and without shame about sexual acts and activities. (p.144)

This would be a tall order for any witness, let alone one who has to speak in public about the most intimate of violations. Konradi (1996, 2007), Payne (2009) and WNC's (2009) findings from studies with victim-survivors offer directions for change:

- Victim-survivors should, and have a right to, be kept informed at all stages in the legal process.
- More detailed and thorough explanations need to be provided when cases are discontinued.
- Victim-survivors should be encouraged and helped to be active parties in the prosecution process.
- Victim-survivors should have the right to support from someone not involved in the case either personally or professionally – this includes ISVAs and specialist sexual violence support services.
- Victim-survivors should be able to have support in court from whoever they want.
- Victim-survivors should get legal representation separate from the CPS.
- There should be a review of the appeal process.
- There should be mandatory training for every professional dealing with sexual violence.
- Civil and criminal justice need to be integrated, with recognition that safety is also an issue for victim-survivors of rape.

6. Response of the health system

We were asked to look at the impact of sexual assault referral centres (SARCs), forensic medical examinations and other healthcare responses (including examples of good practice). In addition, we were asked to look at what a good outcome looks like from a health and mental health perspective; however, we found little evidence to review on these latter questions.

6.1 Sexual assault referral centres

There is strong evidence that SARCs are successful at providing appropriate treatment to victim-survivors of recent sexual violence but currently only limited, emerging evidence that they improve conviction rates.

A SARC is defined as a:

... one-stop location where victims of rape, sexual abuse and serious sexual assault, regardless of gender or age, can receive medical care and counselling, and have the opportunity to assist a police investigation, including undergoing a forensic examination, if they so choose.
(Department of Health, Home Office and Association of Chief Police Officers, 2009, p.4)

Their primary stated aim is to provide support and healthcare to victim-survivors rather than to improve investigations and prosecutions. Other intended benefits include: higher standard of victim-survivor care; greater satisfaction; more support and options; specialist health services; increased coordination; liaison with third sector; and the development of forensic expertise, which will improve evidence and increase the potential of bringing offenders to justice, thus reducing attrition (Department of Health, Home Office and Association of Chief Police Officers, 2009). However, SARCs vary widely in their model of service provision and staff have varying levels of skill and experience (ibid.; Pillai and Paul, 2006) with national minimum standards only introduced in autumn 2009.

Two Home Office reports (Kelly, Lovett and Regan, 2005; Lovett, Regan and Kelly, 2004) published when the SARC network was just beginning to expand show that generally most victim-survivors attending SARCs were happy with the way they were treated (especially in integrated sites), describing them as 'safe', 'reassuring' and 'private' locations (Lovett, Regan and Kelly, 2004). In particular, victim-survivors valued: the provision of female examiners and staff; proactive follow up; advocacy and case tracking; and practical support. Similar benefits have been noted in more recent single-site evaluations (Regan, Kelly and Lovett, 2008; Robinson, 2009;

Schonbucher, Kelly and Horvath, 2009), Since the Home Office reports of the mid-2000s there have been no further multi-site evaluations.

6.1.1 Criminal justice outcomes

In terms of criminal justice outcomes, there is no firm answer to the question of to what extent SARCs reduce attrition. There is also an important gap in knowledge about the range and effectiveness of different models in the expanding SARC network, especially given that SARC expansion is a key government commitment (HM Government, 2007; Home Office, 2008). A national, multi-site, quasi-experimental study is more possible now than it has been in previous years and should be conducted. Evidence is therefore classed as emerging and limited, from both UK and US sources.

In the UK, Kelly, Lovett and Regan (2005) found victim-survivors were more likely to complete the initial investigative process in SARC areas compared with non SARC areas, and also that the conviction rates were slightly higher in the SARC areas than the national average. However, because of the different methodologies used to calculate the national average and the SARC areas, and because of a range of extraneous variables that were not controlled for, it is not possible to state with certainty that the existence of SARCs per se increased conviction rates.

Evidence from elsewhere is a little more developed (predominantly from the USA and Canada), but not always relevant to the England and Wales context. For example, some of the problems identified in the USA by Campbell et al. (2009), with some victim-survivors feeling frustrated, hurt or disempowered when their wishes to not have the examination or not support a prosecution have not been respected, have not been found to date in England and Wales. Other issues are more relevant. One of the key findings from an article outlining a number of related studies by Campbell et al. (2009) was that 'evidence begets more evidence' (p.v). By this, they mean that although a sexual assault nurse examiner (SANE) is focusing on patient care rather than the investigation or prosecution of cases, SANE involvement was associated with increased investigational effort in a case. For example, they suggest the medical evidence collected by a SANE may enable a crucial lead for law enforcement to follow up evidentially. Another key finding in the Campbell et al. (2009) study is that more cases moved through the system to guilty pleas or guilty convictions in a before and after quasi-experimental design.

6.2 Forensic medical examinations

There is strong evidence of the positive role that quality forensic medical examinations can play, both in terms of victim-survivor care and criminal justice outcomes.

6.2.1 Victim-survivor experiences

Du Mont, White and McGregor (2009) interviewed 19 women who had undergone forensic medical examinations following sexual assault in Canada. They asked about their experience and expectations and found that some women described being simultaneously empowered and distressed by the examination. Some misunderstood the optional nature of the examination and equated it with the guarantee of further help and support. However, the overall view was one of satisfaction with the forensic nurse examiners. In a second study (McGregor et al., 2009), they conducted a systematic search and identified 20 relevant articles to evaluate indicators of women-centred care in relation to sexual assault examinations. The indicators they found most often were respect, safety, restoring control and connections to community. The articles they reviewed were largely silent on the complexities of consent in examinations, social justice issues and the need for gender-sensitive training.

6.2.2 Criminal justice outcomes

McGregor, Du Mont and Myhr (2002) retrospectively reviewed police-reported cases at a Canadian sexual assault service between 1993 and 1997 to examine whether forensic medical evidence was associated with a successful prosecution. They found an overall conviction rate of 11% (convicted as charged in 7.1% of cases and on a lesser charge in 3.9%), and that the inclusion of forensic medical evidence was associated with a higher likelihood of charges being filed. However, they found the only variable associated with conviction was a 'severe' clinical injury extent score and not the presence of forensic medical evidence in itself.

Campbell et al. (2009) compared victim-survivor characteristics, the characteristics of the assault and the availability of forensic medical evidence in an attempt to build a model to predict or explain case outcomes. They found that availability of forensic evidence was the most significant factor, above and beyond the victim-survivor and assault characteristics.

6.2.3 Gender of examiner

There are often questions asked about the significance of the gender of the person doing the forensic medical examination. UK research shows that some areas can find it particularly difficult to recruit female doctors and that the shortage of female examiners is problematic (Kirkham and Westmarland, 2008; Pillai and Paul, 2006). Research in the USA by Eckert, Sugar and Fine (2004) used documentation from 662 consecutively reported sexual assault cases in the USA to study whether the examiner's level of experience or gender was associated with the recorded prevalence of trauma. They found no association between gender and documented injuries. Therefore, the quality of an examiner's report does not seem to be linked to the gender of the examiner. However, Eckert, Sugar and Fine (2004) did not look at associations between gender and any secondary victimisation caused by the examination itself or victim-survivor preference.

When victim-survivor preference and likelihood to continue examination is taken into account, a clear preference for female examiners is evident. Using a questionnaire with 177 victim-survivors from three UK SARCs, Chowdhury-Hawkins et al. (2008) investigated what victim-survivors' preference was, and what they would do if their preferred gender of examiner was not available. They found that most respondents said they would prefer a female forensic medical examiner (78.4%) and a similar proportion said they would prefer the crisis worker to be female (74.6%). Since only 5.1% of the sample (n=9) were male, the overall figures are largely reflective of the preferences of female victims. When just the males are looked at, a third said they would prefer a female examiner and the remainder expressed no preference with one exception (whose preference was for a male examiner). Over half the men said they would prefer a female crisis worker and the remainder said they had no preference. Overall, they found that nearly 100% of victim-survivors said they would continue with the examination if it were carried out by a female examiner, but 43.5% said they would not continue if the examiner were male. The authors conclude that SARCs should continue to try and recruit female examiners, where possible within the limits of employment law. There are a range of other UK studies that have confirmed this strong preference for female examiners and/or practitioners (Lovett, Regan and Kelly, 2004; Payne, 2009; Regan, Kelly and Lovett, 2008; Robinson, 2009; Schonbucher, Kelly and Horvath, 2009).

6.3 Other healthcare responses

There is only limited or emerging evidence available on counselling outcomes. In its World Report on Violence and Health, the World Health Organization (2002) notes the importance of determining effective responses:

Interventions must also be studied to produce a better understanding of what is effective in different settings for preventing sexual violence and for treating and supporting victims. (p.173)

Regarding counselling, there is academic evidence from the USA which is not easily transferable to the UK context since the research takes an overly psychiatric approach than is traditional in the UK. However, there is a multi-site evaluation ongoing and there is grey literature from voluntary and community sector organisations.

6.4 Counselling

Vickerman and Margolin (2009) reviewed 32 articles to evaluate empirical support for a range of treatments for women sexually assaulted during adolescence or adulthood. They found that the treatment targets in the majority of studies were to reduce post-traumatic stress disorder (PTSD), anxiety and/or depression. The most successful treatments according to these outcomes were cognitive processing therapy (which aims to identify traumatic experiences and integrate them into pre-existing schemas) and prolonged exposure (which aims to decrease anxiety associated with rape memories). It is worth noting that most of these studies are US based and many have very small sample sizes (as few as $n=5$). Therefore, while this review article is very useful in that it is the only one of its kind identified in this assessment of evidence (in focusing on impact), it is relatively narrow in its focus and the findings do not necessarily convert to the England and Wales context.

Taylor and Harvey (2009) conducted a meta-analysis on the effects of psychotherapy on sexual assault victim-survivors. They found that individual therapies had better outcomes than group work approaches. Group work recurs as something victim-survivors appreciate or want, but there is relatively little research on its effectiveness. Regarding the UK, a research study is ongoing in the North East and Cumbria investigating the impact of rape crisis and other sexual violence services on health, mental health and well-being using the newly developed 'taking back control' tool (Westmarland and Alderson, 2009). There is also a range of positive,

often life-changing, feedback from women who have accessed rape crisis and other sexual violence services available in voluntary and community sector annual reports and in the focus group data collated by the Women's National Commission across three recent policy reviews.⁷

6.5 What a good outcome looks like

There have been no specific studies looking at what health professionals class as a good outcome for rape victim-survivors. It may be implied that disclosure in itself is a good outcome, since disclosure may lead to accessing support and/or treatment. We know far more about this in relation to domestic violence than we do specifically on sexual violence. However, there is little known about the outcomes for those who are asked about domestic violence (Taket et al., 2003).

From a public health perspective, prevention is seen as a key aim (McMahon, 2000). In terms of domestic violence, the Department of Health (2000) class early intervention as important to prevent a violent and abusive situation escalating. However, it is unclear how this might translate to sexual violence outside of an intimate partner relationship, for example, for adult survivors of child rape and other sexual abuse.

⁷ The consultation on the Violence Against Women and Girls Strategy, Sara Payne's review and the main report from the Taskforce on the Health Aspect of Violence Against Women and Children.

7. Attitudes to and stereotypes of rape

We were asked to look at how different groups of people vary in their attitudes to rape, and to see if there had been any changes over time. Attitudes to rape, holding rape-supportive attitudes and beliefs in rape myths have been the subject of consistent attention since the issue of rape emerged as a significant social problem in the 1970s. The reason for this is twofold. Firstly, and primarily, because of a range of studies (mostly but not exclusively originating in the USA) that show a correlation between holding rape-supportive attitudes or beliefs in rape myths with both rape proclivity and likelihood to rape. Secondly, and of more recent concern, because of the impact that rape-supportive attitudes can have on jury decision making in rape trials thereby contributing to low conviction rates and miscarriages of justice for victim-survivors.

7.1 Police attitudes

Academic research on police and other criminal justice staff attitudes towards rape is mainly based on qualitative, small-scale samples. The quantitative surveys that have been undertaken are US based (with only one in the UK) and rely upon local samples. There is no longitudinal data to show changes over time, although it is suggested that attitudes may be improving based on recent data (Page, 2008). One consistent finding is an over-estimation of false allegations of rape among police officers. This is supported from a range of sources, including from the quantitative and qualitative research and from police officers themselves. In Page's (2008) study of 891 US police officers, 10% responded that the majority (between 51% and 100%) of women lie about being raped and a further 53% responded that between 11% and 50% of reports are false. Qualitative research with police in England and Wales shows similar attitudes (Kelly, Lovett and Regan, 2005).

In research that compares police attitudes with those of students (Brown and King, 1998) and the general population (Field, 1978), the gender of respondent was found to be more important than occupation. Research that has compared rape crisis with criminal justice staff (Feldman-Summers and Palmer, 1980; Field, 1978) found rape crisis staff held significantly different views on a number of items. However, these studies are extremely dated and are US based (with the exception of Brown and King, 1998).

There have been two major public outcries based on television documentaries showing negative police attitudes to rape. In 1982 officers were shown aggressively interviewing a rape victim-survivor about her behaviour and the truthfulness of the allegation in Roger Graef's 'A Complaint of Rape'. *Dispatches*, over two decades later in 2006,

broadcast a documentary of undercover footage showing police officers failing to collect available evidence and saying that they would not report to the police if they were raped .

Although most Rape Crisis Centres (RCCs) now work closely with the police in the UK, a survey showed that only 19% of rape crisis workers said that they personally would make a police report if they were raped by someone they knew (Westmarland, 2004). Police attitudes to rape involving alcohol consumption were widely criticised in media coverage of the Worboys case (discussed earlier), and it is possible that these attitudes also contributed to the initial under-reporting and investigatory failings in this case.

7.2 Healthcare professionals' attitudes

Very few academic studies or grey literature could be found about health and mental health professionals' attitudes to rape, especially with respect to England and Wales. From the available research, it would appear that healthcare professionals' attitudes are less problematic than those held by police and other criminal justice professionals. However, this could be because of the limited research and/or the higher proportion of females in some healthcare professions.

A study by Williams, Forster and Petrak (1999) of 252 British medical students appears positive, concluding that students were well informed on legal issues and the facts of rape. However, it is worth noting that the students in this sample were those who had chosen to attend teaching sessions on sexual assault and may therefore have already held different views to those who did not attend. It is also worth highlighting just how large a gender difference was apparent, with female students more positive in their responses – with 13 of the 20 attitudinal items showing significant differences in statements such as 'a woman should be responsible for preventing her own rape'. In Canada, a questionnaire with 77 psychiatric nurses was also optimistic, showing that the nurses had a high level of knowledge and experience of dealing with rape and mostly did not hold victim-blaming attitudes (Boutcher and Gallop, 1996). In this study, age was the strongest predictor of attitudes, with younger nurses significantly less likely than older nurses to hold hostile views towards sexual assault, rape and incest victim-survivors.

In the USA, White and Robinson Kurpius (1999) compared undergraduate students, counselling postgraduate students and mental health professionals' attitudes to rape. They found that undergraduates held the most negative attitudes towards rape victims, followed by counselling postgraduate students. Mental health professionals held the least negative attitudes. In general, males held more negative attitudes than females, with the exception of the counselling postgraduates who held similar attitudes. Male students held the most negative attitudes while female mental health professionals held the least. This gender difference was also found in a US study of 38 mental healthcare professionals, which found females were significantly more likely than males to explain rape in terms of societal factors (e.g. 'the prevalence of rape is directly related to our societal values') (Resick and Jackson, 1981).

7.3 General population attitudes

There is widespread agreement that public attitudes to rape need to change (see, e.g., HM Government, 2007; Westmarland, 2008a). As mentioned earlier, we found no longitudinal research on attitudinal change (with the exception of studies evaluating the impact of specific interventions). However, there have been three large-scale polls of public attitudes to rape that have asked similar questions with similar methodologies (Amnesty International, 2005; Home Office, 2009; Scottish Executive, 2007). As explained below, we found no evidence of overall change in public attitudes to rape throughout the last four years. However, some evidence of an age effect was found, with younger people less likely to hold victim-blaming attitudes than older people.

In 2005 a poll of 1,095 adults found that between 22% and 37% held victim-blaming attitudes across a range of situations, e.g. if a woman was drunk or had been acting flirtatiously (Amnesty International, 2005). Out of the categories examined, this was highest if the woman failed to say 'no' clearly (37%) and lowest if a woman had had many sexual partners or was walking alone in a dangerous or deserted area (22% said at least partly responsible to these). In 2007 a poll of 992 adults reported similar findings (Scottish Executive, 2007). Out of the categories examined, this was highest if a woman was flirting (32%) and lowest if she had had lots of sexual partners (18%). The most recent poll, in 2009, of 915 adults found there remain circumstances in which a large proportion of people believe a woman should be held at least partly responsible for being sexually assaulted or raped (Home Office, 2009). Out of the categories examined, this was highest if the woman does not clearly say 'no' to the man (49% said at least

partly responsible) and lowest if a woman was out walking alone at night (14% said at least partly responsible).

Some of the findings were remarkably similar across all these surveys, despite the time difference. For example, all found at least a quarter of respondents believed that women should, in certain circumstances, be held responsible for a sexual assault or rape. Despite a range of poster and radio campaigns aimed at attitudes towards women, alcohol and rape, more people held the woman responsible in 2009 than did in 2004 (36% compared with 30%). However, this was lower in Scotland (27%). A similar pattern is evident regarding 'flirting' (34% held responsible in 2004 compared with 43% in 2009). Again this was lower in Scotland (32%). Although differences between the studies may be expected because of variations in question wording, there is no strong evidence of victim-survivor blaming attitudes dissipating over the last five years. It is possible that the slightly lower victim-blaming attitudes in Scotland may be reflective of the greater investment in public awareness campaigns in Scotland,⁸ or it may simply be a 'recency effect' since the survey took place shortly after a domestic abuse awareness campaign.

One optimistic finding across the Amnesty International (2005) and Scottish Executive (2007) studies is that younger people were less likely to hold some rape-supportive attitudes than older people. This may represent the start of a generational shift. For example, in the Amnesty International (2005) study older people (aged 65+) were more likely than the total sample to hold a woman at least partially responsible for being raped if she was drunk (54% compared with 30%). In the Scottish Executive (2007) study, 42% of participants aged 65+ held the woman at least partially responsibly compared with 19% of participants aged 18–24 and 16% of participants aged 25–34. The Scottish study also found a range of gender differences; for example, males were more likely than females to state that a woman held some responsibility for rape if she was drunk (30% compared with 25%) or if she was flirting (34% compared with 29%). However, this was not as pronounced in the Amnesty International (2005) study. This cautious optimism is echoed within a recent qualitative study into the way rape myths are promoted but also how they are challenged and resisted (Westmarland and Graham, 2010).

⁸ For example, Rape Crisis Scotland's 'This is not an invitation to rape me' campaign and the Scottish Executive's annual 'Domestic abuse: there's no excuse' campaign.

8. Impact of legal and policy changes

This review was also required to assess evidence about the impact of recent legal and policy changes on responses to rape by public bodies.

8.1 Legislative changes

8.1.1 Sexual Offences Act 2003

The Sexual Offences Act 2003 (SOA) was the first contemporary overhaul of sex offences legislation, modernising its foundations and drawing on the then knowledge base. The majority of the commentary on the SOA has been published in legal books and journals (Bohlander, 2005; Elvin, 2008; Finch and Munro, 2007; Spencer, 2004; Temkin and Ashworth, 2004; Westmarland, 2008b), with most welcoming its parameters. Debate has centred on drunken consent and the provisions relating to consent (e.g. Elvin, 2008) with the suggestion that the SOA needs to be amended to include more specificity about which circumstances vitiate consent. Despite significant rulings in leading cases (such as *R v. Dougal*, 2005; *R v. Bree*, 2007; *R v. H*, 2007),⁹ confusion remains both among the general public and the courts about capacity to consent when alcohol has been consumed by a victim-survivor (Wallerstein, 2009). In 2006 the Home Office published the only evaluation, termed a 'stock take', into the effectiveness of the SOA, concluding there was little evidence to show that it has helped to secure a greater number of convictions against sex offenders, particularly rapists, and that awareness about the Act and its provisions remains patchy.

8.1.2 Rape shield legislation

Rape shield legislation is designed to curtail the use of questioning and evidence about the past sexual history and/or sexual character of the victim-survivor in court. Versions of it have been introduced since the 1970s in many common law jurisdictions (e.g. Australia, Canada, New Zealand, Scotland and the USA). In England and Wales, sections of the Youth Justice and Criminal Evidence Act 1999 (YJCEA) were intended to make provisions more effective and transparent and to restrict the use of such evidence to situations where its relevance was more than undermining the credibility of the complainant. There are two conflicting assessments of its impact. Neil Kibble's (2000, 2005, 2008) research and commentary concludes that the judiciary are exercising appropriate discretion and he has criticised the work of Kelly, Temkin and Griffiths (2006) which took the opposite view.

⁹ *R v. Dougal* (2005) Swansea Crown Court; *R v. Bree* (2007) EWCA Crim 804 [2007] 3 Cr App R 13; *R v. H* [2007] EWCA Crim 2056.

However, the latter's comprehensive evaluation found that sexual history evidence was still used in more than three-quarters of rape trials; the procedural safeguards were rarely used as set out in the law; and almost half of the judges interviewed had only vague knowledge of the YJCEA and were unaware of the rules around applying it. Further, the grey literature supports these assertions with accounts from survivors also referring to the common use of innuendo. Victim-survivors remain concerned about whether sexual history evidence will be discussed in court and this has an impact on their decision making, from the decision to report, to their appearance in court (Payne (2009); this finding is also supported by recent data from a larger group of victim-survivors (Women's National Commission, 2009)).

In summary, the available evidence suggests that all jurisdictions have encountered similar problems in the effective implementation of 'rape shield' legislation, and as a result this legal strategy is thought to have had limited effectiveness (Birch, 2002; Burman, 2009; Kelly, Temkin and Griffiths, 2006; Temkin, 2002). It is also worth noting Louise Ellison's (2007) observation of a growing trend in England and Wales to video interview adult victim-survivors of rape in the wake of the YJCEA, even though relevant statutory provisions for admitting such a video recording as the complainant's evidence in chief at trial have not yet been implemented.

8.1.3 Special measures

The YJCEA also introduced special measures – protections for vulnerable and intimidated witnesses to enable them to give best evidence in court. The only evaluation of special measures was conducted by Burton, Evans and Sanders (2006) but they excluded victims of sexual offences, so while their findings are considered here they are not directly relevant. They found only a small number of vulnerable witnesses were identified by the police and that the Crown Prosecution Service (CPS) rarely identified additional vulnerable witnesses. Many vulnerable witnesses are identified when they get to court when it is often too late to set up special measures. The evaluation found no examples of the police and CPS holding strategy meetings to discuss difficult cases in their case tracking. The authors concluded that there is considerable unmet need. Sara Payne (2009) also found that special measures emerged as a highly problematic among the victim-survivors she met, which led her to recommend more research be conducted on how they influence juries and the judiciary. The key issues raised related to: late applications; inconsistencies in when they are granted; and whether use of special measures may count against victim-survivors.

Maier (2007) summarises the findings from the international literature on rape law reform, arguing that all have had limited success in either achieving symbolic goals, such as transforming victim-blaming attitudes within and outside the criminal justice system, or instrumental goals, such as advocating better treatment by the legal system (see also, Clay-Warner and Burt, 2005; Frohmann, 1998; Taslitz, 1999). In her recent research in the USA with rape victim advocates, which is supported by previous studies (e.g. Doyle and Barbato, 1999; Edward and Macleod, 1999), Shana Maier (2007) concludes that:

Goals that have focused on changing attitudes and public perception have not been achieved as a result of rape reform laws. (p.56)

8.2 Impact of policy changes

There has been a range of policy initiatives and new strategies over the last decade (see Chapter 1), often based on evidence and recommendations from research. A range of bodies reviews progress but none has published publicly available reports that trace developments and/or document impacts. These bodies include the Rape Performance Group, the CPS's dedicated rape unit; and the sexual violence and abuse stakeholders advisory group. The first inspection by Her Majesty's Crown Prosecution Service Inspectorate/Her Majesty's Inspectorate of Constabulary (HMCPSI/HMIC, 2002) made a series of concrete proposals, only some of which had been implemented when the issue was revisited five years later. Unsurprisingly, they concluded that many previously identified problematic issues remained and recommendations in *Without Consent* (HMCPSI, 2007) were reiterated and enhanced. The report does note some limited change:

The introduction of STO role, SARCs, WCUs and CPS rape co-ordinators, specialist lawyers and specialist case workers is, without doubt, leading to improvements in the CJS response to rape cases and a more professional approach to the treatment and care of victim-survivors. However 'intention' is not yet translating into fully effective practice on the ground, and several fundamental difficulties persist that are constraining the potential for more significant and sustained improvement. (p.21)

The most recent evidence comes from Sara Payne's (2009) investigation of victim experience, which involved engagement with victim-survivors, the CPS and police and expert stakeholders. She concluded that the ongoing problems were not about the broad contours of the letter of the law,

policies or procedures but that implementation remains inconsistent and previous recommendations and commitments are yet to be actioned.

8.3 Other recent interventions

There has been a range of new interventions introduced in an attempt to improve rape investigations and prosecutions. These include: early evidence kits; improving judicial training; and firming up the process by which judges are 'ticketed' to preside over rape cases. However, there is no evidence about the impact of these. For example, there is no research in England and Wales regarding the impact of rape ticketing or even how many judges have had their rape tickets removed. Pilot work in Australia found that cases conforming to the 'real rape' stereotype, particularly those involving strangers and violence, are still viewed by judges as the most serious form of rape (Kennedy, Eastaugh and Taylor, 2009). Perhaps most relevant to the England and Wales context, this study found:

While judges may articulate an increased awareness of the effects of various types of sexual assault, and acknowledge aggravating factors such as breach of trust, this awareness is either not translating into sentences or is being balanced by the emphasis of other mitigating factors. (p.21)

8.3.1 The potential impact of proposed interventions

One proposal which is yet to be agreed upon is the use of expert evidence in trials to address the way stereotypes and myths about rape affect outcomes. Ellison and Munro (2009c), conducted mock trials with 27 juries, in which expert evidence was given that did no more than provide general empirically uncontested background information about possible and varied reactions of victim-survivors to sexual violence. The evidence was related to three specific issues: calm demeanour of victim-survivors, delayed reporting and lack of physical resistance. Jurors who received evidence on the first two issues were more willing than their non-educated counterparts to accept a wide range of victim-survivor responses. The researchers posit a number of plausible explanations for why the resistance issue was different. In summary, they conclude that general expert evidence or extended judicial instruction would be beneficial in rape cases. This was also a recommendation of the Women's National Commission (2009).

We can conclude, therefore, that while increased attention has been paid to the response to rape by public bodies, and some improvements have been made, especially the expansion of sexual assault referral centres and the introduction of Independent Sexual Violence Advisors, which have had a positive impact on the treatment of victim-survivors, many of the issues identified as problematic in the last decade remain so today. The challenges are to improve outcomes by continuing to address attrition and matters of procedural justice; and to ensure that the process of disclosing and reporting rape is one in which victim-survivors are respected and treated with dignity and in which they are afforded as much control and participation as possible. Stereotypes of rape, rapists and victim-survivors continue to affect responses at all levels, pointing to the need for a range of measures to extend understanding and perception across the piece. If successful, this would decrease unacknowledged rape, increase reporting and change for the better the process of investigation and prosecution for victim-survivors and professionals.

9. Short wins and long hauls

We were asked to identify potential ‘short wins’ and ‘long hauls’ from the evidence that might be taken forward. We have defined ‘short wins’ as those areas already identified as being in need of improvement that can be done immediately, and those things that could realistically be done within an intermediate time period. Long hauls, by contrast, are those that require more time to take effect.

9.1 Immediate short wins

It is vital that the ‘implementation gap’ that currently exists between policy and practice that we have found through much of the literature is closed as a matter of urgency. This was previously highlighted by Her Majesty’s Crown Prosecution Service Inspectorate (HMCPSI) (2007) and by AC Yates (2009). HMCPSI has already identified a need for improvement in the following areas:

- consistency in take-up of advice by rape specialist prosecutors;
- continuity in case management;
- greater proactivity in case building;
- more effective use of bad character evidence;
- better and more de-briefing after trial;
- nationally accredited training programme for specially trained officers and better and more consistency in use of specially trained officers;
- better planned suspect interviews; and
- more widespread use of early evidence kits.

These should be attended to immediately.

9.2 Intermediate short wins

Additional ‘short wins’ identified through this evidence review, which could be addressed in the intermediate short term, are:

- Implement the measures that have been agreed e.g. sexual assault referral centres (SARCs), Independent Sexual Violence Advisors (ISVAs), special measures, specialist rape teams. This means providing support with more resources/money. Further, the measures must be implemented evenly and consistently across England and Wales.
- Announce a national, multi-site, quasi-experimental study evaluating SARCs.
- Introduce national standards for forensic examinations.

- Ensure that rape and its investigation and prosecution remain a policy priority. Possible methods for doing this include putting in place service level agreements. In addition, specifically ensure that rape is mandated as a policy priority for the police – this must come from Her Majesty's Inspectorate of Constabulary.
- Strictly adhere to and enforce no-criming rules.
- Ensure more information/evidence is available for juries and judges in court.
- Make sexual and domestic violence mandatory training in medical curricula. This should be done in a way that encourages an approach to victim-survivors that does not treat them as patients.
- Improve communication throughout the case between those involved in criminal justice processes and the victim-survivor. We recommend one point of contact be used – voluntary sector based ISVAs seem ideally placed to fulfil this role.
- Resolve resourcing issues for sexual violence services through the commissioning of specialist, not generic, services that are able to meet the complex and holistic needs of sexual violence survivors (it is important that these include adult survivors of child sexual abuse).

9.3 Long hauls

The potential 'long hauls' identified through this evidence review are:

- Cost-effectiveness of reforms/changes. When rape investigation and prosecution is done badly it ends up costing more both in immediate financial terms and because longer term more women may end up being assaulted when perpetrators are not caught, e.g. the Worboys and Reid cases.
- Ultimately, long-term cultural change is required to improve victim-survivors' experiences once an assault has happened and ideally, to also to prevent/reduce the number of assaults. This can be achieved through targeted education/awareness raising that focuses on two key areas:
 - young people; and
 - the general public.

- Development of a targeted research agenda including:
 - What we don't know – confirm prevalence and incidence using a specialist, non-crime survey (e.g. *The SAVI Report* (MeGee et al., 2002)); identify the number of cases using 'reasonable belief in consent' defence; determine what constitutes good/bad practice; compare high and low performing areas; and identify types of cases that are no-crimes, where no further action is recommended, or where prosecutions are not taken forward to trial.
 - A longitudinal study of victim-survivors who do and do not report to the police, but who access support – trace what they consider good practice and good outcomes to be, and how they rebuild their selves and lives in the aftermath of sexual violence.
 - An evaluation of implementation of new policies, practices and/or further changes in the law.

References

- Ahrens, C. (2006). Being silenced: the impact of positive social reactions on the disclosure of rape, *American Journal of Community Psychology*, 38, 263–274.
- Amnesty International (2005). *Sexual assault research: summary report*. Prepared by ICM.
- Amstadter, A.B., McCauley, J.L., Ruggiero, K.J., Resnick, H.S. and Kilpatrick, D.G. (2008). Service utilization and help seeking in a national sample of female rape victims, *Psychiatric Services*, 59, 1450–1457.
- Baird, V. (2009). Speech to rape and sexual assault conference, 23 September.
- Birch, D. (2002). Rethinking sexual history evidence: proposals for fairer trials, *Criminal Law Review*, 7, 531–533.
- Bohlander, M. (2005). The Sexual Offences Act 2003 and the Tyrrell principle – criminalising the victims? *Criminal Law Review*, 701–713.
- Boutcher, F. and Gallop, R. (1996). Psychiatric nurses' attitudes toward sexuality, sexual assault/rape, and incest, *Archives of Psychiatric Nursing*, 10(3), 184–191.
- Brown, B., Burman, M. and Jamieson, L. (1993). *Sex Crimes on Trial: The use of sexual evidence in Scottish courts*. Edinburgh: Edinburgh University Press.
- Brown, J. and King, J. (1998). Gender differences in police officers attitudes towards rape: Results of an exploratory study, *Psychology, Crime & Law*, 4(4), 265–279.
- Brown, J., Horvath, M., Kelly, L. and Westmarland, N. (2010). *Has anything changed? Results of a comparative study (1977 - 2010) on opinions on rape*. London: GEO.
- Bryant, M. and Loader, P. (2008). *Report on evidence based decision making in rape*. Holt Heath: Process Evolution.
- Burman, M. (2009). Evidencing sexual assault: Women in the witness box, *Probation Journal, The Journal of Community and Criminal Justice*, 56(4), 1–20.
- Burman, M.L., Jamieson, L., Nicholson, J. and Brooks, O. (2007). *Impact of aspects of the law of evidence in sexual offence trials: An evaluation study*. Edinburgh: Scottish Executive.
- Burton, M., Evans, R. and Sanders, A. (2006). *An evaluation of the use of special measures for vulnerable and intimidated witnesses*. Home Office Research Findings 270. London: Home Office Research, Development and Statistics Directorate.
- Campbell, R. (2008). The psychological impact of rape victims' experiences with the legal, medical, and mental health systems. *American Psychologist*, 68, 702–717.

Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: do rape victim advocates make a difference? *Violence Against Women*, 12, 30–45.

Campbell, R. (1998). The community response to rape: victims' experiences with the legal, medical and mental health systems, *American Journal of Community*, 26, 355–379.

Campbell, R., Patterson, D., Bybee, D. and Dworkin, E.R. (2009). Predicting sexual assault prosecution outcomes: The role of medical forensic evidence collected by sexual assault nurse examiners, *Criminal Justice and Behavior*, 36(7), 712–727.

Campbell, R. and Wasco, S. M. (2005). Understanding rape and sexual assault: 20 years of progress and future directions, *Journal of Interpersonal Violence*, 20, 127–131.

Campbell, R., Patterson, D. and Lichty, L.F. (2005). The effectiveness of sexual assault nurse examiner (SANE) programs: A review of psychological, medical, legal, and community outcomes, *Trauma Violence & Abuse*, 6(4), 313–329.

Campbell, R., Dorey, H., Neageli, M., Grubstein, L.K., Bennett, K.K., Bonter, F., Smith, P., Grzywacz, J., Baker, P.K. and Davidson, W.S. (2004). An empowerment evaluation model for sexual assault programs: Empirical evidence of effectiveness, *American Journal of Community Psychology*, 34, 251–262.

Campbell, R. and Martin, P.Y. (2001). Services for sexual assault survivors: the role of rape crisis centres. In C. Renzetti, J.F. Edleson and R.K. Bergen (Eds). *Source book on violence against women*. Thousand Oaks, CA: Sage.

Campbell, R., Wasco, S.M., Ahrens, C.E., Self, T. and Barnes, H.E. (2001). Preventing the second rape: rape survivors' experiences with community service providers, *Journal of Interpersonal Violence*, 16, 1239–1259.

Campbell, R. and Raja, S. (1999). The secondary victimisation of rape victims: insights from mental health professionals who treat survivors of violence, *Violence & Victims*, 14, 161–175.

Chowdhury-Hawkins, R., McLean, I., Winterholler, M. and Welch, J. (2008). Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs), *Journal of Forensic and Legal Medicine*, 15(6), 363–367.

Clay-Warner, J. and Burt, C.H. (2005). Rape reporting after reforms: Have times really changed? *Violence Against Women*, 11, 150–176.

Clements, C.M. and Ogle, R.L. (2009). Does acknowledgement as an assault victim impact postassault psychological symptoms and coping? *Journal of Interpersonal Violence*, 24(10), 1595–1614.

Cornell, D. (1998). Helping victims of rape: A program called SANE, *New Jersey Medicine*, 2, 45–46.

Cossins, A. (2008). Restorative justice and child sex offences: the theory and the practice, *British Journal of Criminology*, 48(3), 359–378.

Coy, M., Kelly, L. and Foord, J. (2009). *Map of Gaps 2: The Postcode Lottery of Violence Against Women Support Services in Britain*. London: Equality and Human Rights Commission.

Crandall, C. and Helitzer, D. (2003). *Impact evaluation of a sexual assault nurse examiner (SANE) program*, National Institute of Justice Document No. 203276. Washington, DC: National Institute of Justice.

Crown Prosecution Service (2009). *Violence Against Women crime report (2008–2009)*. Accessed on 6 January 2010 from www.cps.gov.uk/publications/docs/CPS_VAW_report_2009.pdf

Curtis Fawley, S. and Daly, K. (2005). Gendered violence and restorative justice: the view of victim advocates, *Violence Against Women*, 11, 603–638.

Daly, K. (2009). Setting the record straight and a call for a radical change: a reply to Annie Cossins on restorative justice and child sex offences. *British Journal of Criminology*, 48(4), 557–566.

Daly, K. and Bouhours, B. (In press). Rape and attrition in the legal process: a comparative analysis of five countries, *Crime and Justice: An Annual Review of Research*, 39.

Daly, K. and Stubbs, J. (2006). Feminist engagement with restorative justice, *Theoretical Criminology*, 10(1), 9–28.

Department of Health (2000). *Domestic violence: A resource manual for health care professionals*. London: Department of Health.

Department of Health, Home Office and Association of Chief Police Officers (2009). *Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres*. London: Department of Health.

Doyle, S. and Barbato, C. (1999). Justice delayed in justice denied: The experiences of women in court as victims of sexual assault. In J. Breckenridge and L. Laing (Eds). *Challenging silence: The innovative responses to sexual and domestic violence*. St Leonards, NSW, Australia: Allen & Unwin.

Du Mont, J., White, D. and McGregor, M.J. (2009). Investigating the medical forensic examination from the perspectives of sexually assaulted women, *Social Science and Medicine*, 68, 774–780.

Eckert, L.O., Sugar, N. and Fine, D. (2004). Factors impacting injury documentation after sexual assault: role of examiner experience and gender, *American Journal of Obstetrics and Gynecology*, 190, 1739–1746.

Edward, K. and Macleod, M. (1999). The reality and myth of rape: Implications for the criminal justice system, *Expert Evidence*, 7, 37–58.

Ellison, L. (2007). Promoting effective case-building in rape cases: A comparative perspective, *Criminal Law Review*, 691–708.

Ellison, L. and Munro, V.E. (2009a). Of 'normal sex' and 'real rape': Exploring the use of socio-sexual scripts in (mock) jury deliberation, *Social & Legal Studies*, 18(3), 291–312.

Ellison, L. and Munro, V.E. (2009b). Reacting to rape: Exploring mock jurors' assessments of complainant credibility, *British Journal of Criminology*, 49(2), 202–219.

Ellison, L. and Munro, V.E. (2009c). Turning mirrors into windows? *British Journal of Criminology*, 49(3), 363–383.

Elvin, J. (2008). Concept of consent under the Sexual Offences Act 2003, *Journal of Criminal Law*, 72, 519–536.

Fawcett Society (2010). *Regional Rape Conviction Rates 2007*. Accessed on 6 January 2010 from www.fawcettsociety.org.uk/index.asp?PageID=942

Feist, A., Ashe, J., Lawrence, J., McPhee, D. and Wilson, R. (2007). *Investigating and detecting recorded offences of rape*. Home Office Online Report 18/07. London: Home Office.

Feldman-Summers, S. and Palmer, G.C. (1980). Rape as viewed by judges, prosecutors, and police officers, *Criminal Justice and Behavior*, 7(1), 19–40.

Field, H.S. (1978). Attitudes toward rape: A comparative analysis of police, rapists, crisis counsellors and citizens, *Journal of Personality and Social Psychology*, 36(2), 156–179.

Finch, E. and Munro, V.E. (2007). The demon drink and the demonized woman: Socio-sexual stereotypes and responsibility attribution in rape trials involving intoxicants, *Social & Legal Studies*, 16(4), 591–614.

Frohmann, L. (1998). Constituting power in sexual assault cases: Prosecutorial strategies for victim management, *Social Problems*, 45, 393–407.

Fry, D. (2007). *A room of our own: sexual assault survivors evaluate services – a research report from the New York City Alliance Against Sexual Assault*. New York: New York City Alliance Against Sexual Assault.

Gill, A. (2009). Narratives of survival: south Asian women's experience of rape. In M.A.H. Horvath and J. Brown (Eds). *Rape: Challenging contemporary thinking*. Collumpton: Willan.

Golding, J.M., Siegel, J.M., Sorenson, S.B., Burnam, M.A. and Stein, J.A. (1989). Social support sources following sexual assault, *Journal of Community Psychology*, 17, 92–107.

Gray-Eurom, K., Seaberg, D.C. and Wears, R.L. (2002). The prosecution of sexual assault cases: Correlation with forensic evidence, *Annals of Emergency Medicine*, 39(1), 39–46.

Hagemann-White, C. (2001). European research on the prevalence of violence against women, *Violence Against Women*, 7(7), 732–759.

Harris, J. and Grace, S. (1999). *A question of evidence? Investigating and prosecuting rape in the 1990s*. London: Home Office.

Hellman, C.M. and House, D. (2006). Volunteers serving victims of sexual assault, *The Journal of Social Psychology*, 146, 117–123.

HM Crown Prosecution Service Inspectorate (2007). *Without Consent: A Report on the Joint Review of the Investigation and Prosecution of Rape Offences*. London: HMCPSI.

HM Crown Prosecution Service Inspectorate and HMIC (2002). *The Report on the Joint Inspection into the Investigation and Prosecution of Cases involving Allegations of Rape*. London: HMCPSI and HMIC.

HM Government (2009). *Together We Can End Violence Against Women and Girls – A Strategy*. London: HM Government.

HM Government (2007). *Cross Government Action Plan on Sexual Violence and Abuse*. London: HM Government.

Hoare, J. and Povey, D. (2008). Violent and sexual crime. In C. Kershaw, S. Nicholas and A. Walker (Eds). *Crime in England in Wales 2007/2008. Volume 1: Findings from the British Crime Survey*. Home Office Statistical Bulletin 07/08. London: Home Office.

Home Office (2009). *Results from the Ipsos Mori poll of telephone interviews with people in England and Wales regarding their opinions on violence against women*. London: Home Office.

Home Office (2008). *Saving lives. Reducing harm. Protecting the public. An action plan for tackling violence 2008-2011*. London: Home Office.

Home Office, Court Service, Crown Prosecution Service (2002). *Action Plan to implement the recommendations of the HMCPSI/HMIC joint investigation into the investigation and prosecution of cases involving allegations of rape*.
www.crimereduction.homeoffice.gov.uk/sexual/sexual21.htm

Hooper, C.A. and Warwick, I. (2006). Gender and the politics of service provision for adults with a history of childhood sexual abuse, *Critical Social Policy*, 26, 467–479.

Hutson, L.A. (2002). Development of sexual assault nurse examiner programs, *Emergency Nursing*, 37, 79–88.

Independent Police Complaints Commission (2010). *Commissioner's Report: IPCC independent investigation into the Metropolitan Police Service's Inquiry into allegations against John Worboys*. www.ipcc.gov.uk/worboys_commissioners_report.pdf

Jenkins, G. and Schuller, R.A. (2007). The impact of negative forensic evidence on mock jurors' perceptions of a trial of drug-facilitated sexual assault, *Law and Human Behavior*, 31(4), 369–380.

Johnson, H., Ollus, N. and Nevala, S. (2008). *Violence Against Women: An International Perspective*. New York: Springer.

Jordan, J. (2009). Worlds apart? Women, rape and the police reporting process. In B. Williams and H. Goodman Chong (Eds). *Victims and Victimisation: A Reader*. Maidenhead: Open University Press.

Jordan, J. (2008a). *Serial Survivors: Women's narratives of surviving rape*. Annandale, Australia: Federation Press.

Jordan, J. (2008b). Perfect victims, perfect policing? Improving rape complainants' experiences of police investigations, *Public Administration*, 86(3), 699–719.

Jordan, J. (2004). The word of a woman: police, rape and the reporting process. *British Journal of Criminology*, 41(4), 679–706.

Kaukinen, C. and Demaris, A. (2009). Sexual assault and current mental health: the role of help-seeking and police response, *Violence Against Women*, 15(11), 1331–1357.

Kebbell, M.R., O'Kelly, C.M.E. and Gilchrist, E.L. (2007). Rape victims' experiences of giving evidence in English Courts: A survey, *Psychiatry, Psychology & Law*, 14(1), 111–119.

Kebbell, M.R., Deperez, S. and Wagstaff, G.F. (2003). The direct and cross examination of complainants and defendants at rape trials: a qualitative analysis of question type, *Psychology, Crime and Law*, 9, 49–59.

Kelly, L. (2002). *A research review on the reporting, investigation and prosecution of rape cases*. London: HMCPSI.

Kelly, L., Temkin, J. and Griffiths, S. (2006). *Section 41: an evaluation of new legislation limiting sexual history evidence in rape trials*. Home Office Online Report 20/06. London: Home Office Research, Development and Statistics Directorate.

Kelly, L., Lovett, J. and Regan, L. (2005). *A gap or a chasm? Attrition in reported rape cases*. Home Office Research Study 293. London: Home Office.

Kennedy, J., Easteal, P. and Taylor, C. (2009). Rape mythology and the criminal justice system: a pilot study of sexual assault sentencing in Victoria, *ACSSA Aware*, 23, 6–12.

Kershaw, C., Nicholas, S. and Walker, A. (Eds) (2008). *Crime in England and Wales 2007/08. Volume 1: Findings from the British Crime Survey*. Home Office Statistical Bulletin 07/08. London: Home Office.

Kibble, N. (2008). Uncovering judicial perspectives on questions of relevance and admissibility in sexual offence cases, *Journal of Law and Society*, 35, 91–107.

Kibble, N. (2005). Judicial discretion and the admissibility of prior sexual history evidence under section 41 of the Youth Justice and Criminal Evidence Act 1999: Sometimes sticking to your guns means shooting yourself in the foot: part 2, *Criminal Law Review*, 263–274.

Kibble, N. (2000). Sexual history provisions: Charting a course between inflexible legislative rules and wholly untrammelled judicial discretion? *Criminal Law Review*, 274–292.

Kingi, V. and Jordan, J. (2009). *Responding to sexual violence: pathways to recovery*. Auckland, New Zealand: Ministry of Women's Affairs.

Kirkham, E. and Westmarland, N. (2008). *An assessment of forensic medical examination (FME) provision for rape cases in the Durham Constabulary area*. Durham: Durham University.

Konradi, A. (2007). *Taking the stand: Rape survivors and the prosecution of rapists*. Westport, CT: Praeger.

Konradi, A. (2001). Pulling strings doesn't work in court: Moving beyond puppetry in the relationship between prosecutors and rape survivors, *Journal of Social Distress and the Homeless*, 10(1), 5–28.

Konradi, A. (1996). Understanding rape survivors' preparations for court, *Violence Against Women*, 2(1), 25–62.

Koss, M.P. (2006). Restoring rape survivors: justice, advocacy and a call to action. In F. Denmark, H. Krass, E. Halpern and J. Sechzer (Eds). *Violence and exploitation against women and girls. Annals of the New York Academy of Sciences*, 1087, 206–234. Boston, MA: Blackwell Publishing on behalf of the New York Academy of Sciences.

Koss, M.P. (1985). The hidden rape victim: Personality, attitudinal, and situational characteristics, *Psychology of Women Quarterly*, 9, 193–212.

Koss, M. and Achilles, M. (2008). *Restorative justice approaches to sexual violence*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. www.vawnet.org

Larcombe, W. (2002). The 'ideal' victim v. successful rape complainants: not what you might expect, *Feminist Legal Studies*, 10, 131–148.

Lees, S. (1996). *Ruling passions: sexual violence reputation and the law*. Buckingham: Open University Press.

Lievore, D. (2005). *No longer silent: a study of women's help-seeking decisions and service responses to sexual assault*. A report prepared by the Australian Institute of Criminology for the Australian Government's Office for Women. Canberra, Australia: Australian Institute of Criminology.

Littleton, H., Axsom, D., Radecki Breitkopf, C. and Berenson, A. (2006). Rape acknowledgment and postassault experiences: how acknowledgment status relates to disclosure, coping, worldview, and reactions received from others, *Violence and Victims*, 21, 765–782.

Lonsway, K., Archambault, J. and Lisak, D. (2009). *False reports: moving beyond the issue to successfully investigate and prosecute non-stranger sexual assault*. Alexandria, VA: National Center for the Prosecution of Violence Against Women.

Lovett, J. and Horvath, M.A.H. (2009). Alcohol and drugs in rape and sexual assault. In M.A.H. Horvath and J. Brown (Eds). *Rape: Challenging contemporary thinking*. Collumpton: Willan.

Lovett, J. and Kelly, L. (2009). *Different systems, similar outcomes? Tracking attrition in reported rape cases in 11 European countries*. London: Child and Woman Abuse Studies Unit.

Lovett, J., Regan, L. and Kelly, L. (2004). *Sexual Assault Referral Centres: developing good practice and maximising potentials*, Home Office Research Study 285. London: Home Office.

Macy, R.J., Giattina, M.C., Parish, S.L. and Crosby, C. (2010). Domestic violence and sexual assault services, *Journal of Interpersonal Violence*, 25(10), 3–32.

Maier, S.L. (2007). Rape victim advocates' knowledge and insight on rape laws, *Women and Criminal Justice*, 18(4), 37–62.

Martin, P.Y. (2005). *Rape Work: Victims, Gender & Emotions in Organization and Community Context*. New York: Routledge.

Martinez, M., Schröttle, M., et al. (2007). *Perspectives and standards for good practice in data collection on interpersonal violence at European level*.
www.cahrv.uni-osnabrueck.de/reddot/FINAL_REPORT__29-10-2007_.pdf

Maxwell, C.D., Robinson, A.L. and Post, L.A. (2003). The impact of race on the adjudication of sexual assault and other violent crimes, *Journal of Criminal Justice*, 31, 523–538.

McGee, H., Garavan, R., de Barra, M., Byrne, J. and Conroy, R. (2002). *The SAVI Report. Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence*. Dublin: Liffey Press.

McGregor, M.J., Du Mont, J., White, D. and Coombes, M.E. (2009). Examination for sexual assault: evaluating the literature for indicators of women-centered care, *Health Care Women International*, 30(1–2), 22–40.

McGregor, M.J., Du Mont, J. and Myhr, T.L. (2002). Sexual assault and forensic medical examination: is evidence related to successful prosecution? *Annals of Emergency Medicine*, 39(6), 639–647.

McMahon, P.M. (2000). The public health approach to the prevention of sexual violence, *Sexual Abuse: A Journal of Research and Treatment*, 12(1), 27–37.

Ministry of Justice (2008). *Criminal Statistics: England and Wales 2007*. London: Ministry of Justice. Accessed on 20 January 2010 from www.justice.gov.uk/publications/docs/crim-stats-2007-tag.pdf

Myhill, A. and Allen, J. (2002). *Rape and sexual assault of women: the extent and nature of the problem: Findings from the British Crime Survey*. Home Office Research Study 237. London: Home Office.

Nasta, A., Shah, B., Brahmanandam, S., Richman, K., Wittels, K., Allsworth, J. and Boardman, L. (2005). Sexual victimization: incidence, knowledge and resource use among a population of college women, *Journal of Pediatric and Adolescent Gynecology*, 18(2), 91–96.

National Council to Reduce Violence Against Women and Children (2009). *Time for action: the national council's plan for Australia to reduce violence against women and their children, 2009–2021*. Canberra, Australia: Department for Families, Housing, Community Services and Indigenous Affairs.

O'Brien, C. (1996). Sexual assault nurse examiner program coordinator, *Emergency Nurses Association*, 22, 532–533.

Page, A.D. (2008). Gateway to reform? Policy implications of police officers' attitudes toward rape, *American Journal of Criminology*, 33, 44–58.

Painter, K. (1991). *Wife rape, marriage and the law – survey report: key findings and recommendations*. Manchester: University of Manchester, Department of Social Policy and Social Work.

Pande, S. (2009). *Name and Shame: An exploratory study into the relationship between availability of sexual vocabulary in Hindi and its impact in disclosure of sexual violence*. MA dissertation, London Metropolitan University.

Payne, S. (2009). *Rape: The victim Experience Review*. London: Home Office.

Peterson, Z.D. and Muehlenhard, C.L. (2004). Was it rape? The function of women's rape myth acceptance and definition of sex in labelling their own experiences, *Sex Roles – A Journal of Research*, 51(3/4), 129–144.

Pillai, M. and Paul, S. (2006). Facilities for complainants of sexual assault throughout the United Kingdom, *Journal of Clinical Forensic Medicine*, 13, 164–171.

Papadopoulos, L. (2010). *Sexualisation of Young People Review*. London: Home Office.

Povey, D., Coleman, K., Kaiza, P. and Roe, S. (2009). *Homicides, firearm offences and intimate violence. Supplementary Volume 2 to Crime in England and Wales 2007/08*. Home Office Statistical Bulletin. London: Home Office.

Regan, L., Kelly, L. and Lovett, J. (2008). *Moving On Up? Evaluation of the Daffodils Sexual Assault Referral Centre*. Unpublished final report for funders (note the name is anonymised).

Renner, K.E. (2002). Re-conceptualizing sexual assault from an intractable social problem to a manageable process of social change. In D. Kelley and J. Hodgson (Eds). *Sexual violence: policies, practices and challenges*. Westport, CT: Greenwood Publishing.

Resick, P.A. and Jackson, T.L. (1981). Attitudes toward rape among mental health professionals, *American Journal of Community Psychology*, 9(4), 481–490.

Robinson, A. (2009). *Independent sexual violence advisors: a process evaluation*. www.homeoffice.gov.uk/rds/pdfs09/horr20.pdf

Roe, S., Coleman, K. and Kaiza, P. (2009). Violent and Sexual Crime. In A. Walker, J. Flatley, C. Kershaw and D. Moon (Eds). *Crime in England and Wales 2008/09*, Home Office Statistical Bulletin 11/09. London: Home Office.

Sampsel, K., Szobota, L., Joyce, D., Graham, K. and Pickett, W. (2009). The impact of sexual assault/domestic violence program on ED care, *Journal of Emergency Nursing*, 35(4), 282–289.

Schonbucher, V., Kelly, L. and Horvath, M.A.H. (2009). *Archway: Evaluation of the Pilot Scottish Rape and Sexual Assault Referral Centre. Final report for Greater Glasgow and Clyde NHS Trust*, June.

Schuller, R. and Klippenstardine, M.A. (2004). The impact of complainant sexual history evidence on juror decisions: considerations from a psychological perspective, *Psychology, Public Policy and Law*, 10, 321–342.

Schumm, J., Briggs-Philips, M. and Hobfoll, S. (2006). Cumulative interpersonal traumas and social support as risk and resiliency factors in predicting PTSD and depression among inner-city women, *Journal of Traumatic Stress*, 19(6), 825–836.

Scottish Executive/TNS System 3 (2007). *Findings from the Wave 10 post-campaign evaluation of the Domestic Abuse Campaign 2006/07*. Edinburgh: Scottish Executive.

Spencer, J.R. (2004). The Sexual Offences Act 2003: (2) – Child and family offences, *Criminal Law Review*, 347–360.

Taket, A., Nurse, J., Smith, K., Watson, J., Shakespeare, J., Lavis, V., Mulley, K. and Feder, G. (2003). Routinely asking women about domestic violence in health settings, *British Medical Journal*, 327(7416), 673.

Taslitz, A. (1999). *Rape and the culture of the courtroom*. New York: New York University Press.

Taylor, N. (2007). Juror attitudes and biases in sexual assault cases, *Trends and Issues in Crime and Criminal Justice*, 344, August. Canberra: Australian Institute of Criminology.

Taylor, J.E. and Harvey, S.T. (2009). Effects of psychotherapy with people who have been sexually assaulted: A meta-analysis, *Aggression and Violent Behavior*, 14(5), 273–285.

Taylor, N. and Joudo, J. (2005). *The impact of pre-recorded video and closed circuit television testimony by adult sexual assault complainants on jury decision-making: an experimental study*. Research and public policy series no. 68.

Temkin, J. (2002). *Rape and the legal process*, 2nd edition. Oxford: Oxford University Press.

Temkin, J. (2000). Prosecuting and defending rape: perspectives from the Bar, *Journal of Law and Society*, 27, 219–248.

Temkin, J. and Ashworth, A. (2004). Rape, sexual assaults and the problems of consent, *Criminal Law Review*, 328–346.

Ullman, S.E., Starzynski, L.L., Long, S.M., Mason, G.E. and Long, L.M. (2008). Exploring the relationships of women's sexual assault disclosure, social reactions and problem drinking, *Journal of Interpersonal Violence*, 23(9), 1235–1257.

Ullman, S.E. and Townsend, S. (2007). What is an empowerment approach to working with sexual assault survivors? *Journal of Counselling Psychology*, 36(3), 299–312.

Ullman, S.E. and Filipas, H.H. (2001). Predictors of PTSD symptom severity and social reactions in sexual assault victims, *Journal of Traumatic Stress*, 14, 393–413.

US Department of Justice: Bureau of Justice Statistics (2002). *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992–2000*. Washington, DC: US Department of Justice.

Van Wormer, K. (2009). Restorative justice as social justice for victims of gendered violence: a standpoint feminist perspective, *Social Work*, 54(2), 107–116.

Vickerman, K.A. and Margolin, G. (2009). Rape treatment outcome research: Empirical findings and state of the literature, *Clinical Psychology Review*, 29(5), 431–448.

Walby, S. (2005). Improving the statistics on violence against women, *Statistical Journal of the United Nations Economic Commission for Europe*, 22(4), 193–216.

Wallerstein, S. (2009). 'Drunken consent is still consent' – or is it? A critical analysis of the law on drunken consent to sex following rape, *Journal of Criminal Law*, 73, 318–344.

Wasco, S. and Campbell, R. (2002). Emotional reactions of rape victim advocates: a multiple case study of anger and fear, *Psychology of Women Quarterly*, 26, 120–130.

Westmarland, N. (2008a). Rape's a Real Crime. *The New Statesman*, 10 July.

Westmarland, N. (2008b). Rape Law Reform in England and Wales. In C.P. Nandini (Ed.). *Rape Law and Reform – Comparative Perspectives*. Hyderabad, India: ICFAI University Press.

Westmarland, N. (2004). *Presentation to Rape Crisis conference*, Stoke-on-Trent, February.

Westmarland, N. and Graham L. (2010). The promotion and resistance of rape myths in an internet discussion forum, *The Journal of Social Criminology*, 1 (2), 80–104.

Westmarland, N. and Alderson, S. (2009). *Development of a tool to measure the health, mental health and well-being impacts of accessing rape crisis services*. Poster presentation given at SVRI Conference, Johannesburg, South Africa, July.

White, B.H. and Robinson Kurpius, S.E. (1999). Attitudes toward rape victims – effects of gender and professional status, *Journal of Interpersonal Violence*, 14, 989–995.

Williams, E. and Stanko, B. (2009). Reviewing rape and rape allegations in London: what are the vulnerabilities of the victims who report to the police? In M.A.H. Horvath and J. Brown (Eds). *Rape: Challenging contemporary thinking*. Collumpton: Willan.


Williams, L., Forster, G. and Petrak, J. (1999). Rape attitudes amongst British medical students, *Medical Education*, 33, 24–27.

Women's National Commission (2009). *Home Office Victims' Experience Review, WNC Report from Women's Discussion Groups, September – October 2009*. www.thewnc.org.uk/publications/cat_view/90-violence-against-women.html?orderby=dmdate_published

Women's Resource Centre and Rape Crisis (2008). *The Crisis in Rape Crisis: A survey of Rape Crisis (England & Wales) Centres*. London: Women's Resource Centre.

World Health Organization (2002). *World Report on Violence and Health*. Geneva: WHO.

Yates, J. (2009). We've got to reinvent rape investigation, *Guardian.co.uk*, 26 March.



Government Equalities Office
9th Floor
Eland House
Bressenden Place
London SW1E 5DU

Tel: 030 3444 0000
Email: enquiries@geo.gsi.gov.uk
www.equalities.gov.uk

© Crown copyright 2010

JN302741